ADVISOR

December 2019

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Psychological Maltreatment

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This article describes how integrated behavioral health care, in pediatric primary care and school-based programs, can prevent and proactively address psychological maltreatment of children. Risk factors for psychological maltreatment are outlined, including community, family, caregiver, and child. The benefit of integrated care models in providing access to evidence-based interventions in settings that are familiar and comfortable to families is highlighted. A three-tiered system approach is utilized that includes universal prevention (tier 1), targeted support (tier 2), and intensive intervention (tier 3) to address a wide range of needs and strives to provide services before involvement with child protective services. Two specific models of intervention are detailed with case examples: HealthySteps in pediatric primary care and an elementary school-based mental health program that includes Cam's Classroom, a universal program.

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Psychological Maltreatment—A Major Child Health, Development, and Protection Issue

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Key words: Psychological maltreatment, abuse, neglect, emotional abuse, emotional neglect, child maltreatment, violence against children, child caregiving, child health, child rights, child well-being, child protection, child adverse experiences

APSAC Encourages Attention to Psychological Maltreatment[1]

The American Professional Society on the Abuse of Children (APSAC) is taking the issue of psychological maltreatment (PM) very seriously and has supported initiatives and activities toward understanding and remedy. A multiple-pronged approach has been applied to include the following: (a) a revision of APSAC guidelines on the topic (APSAC Taskforce, 2017); (b) a PM chapter in the *APSAC Handbook on Child Maltreatment, Fourth Edition* (Hart et al., 2017); (c) a PM monograph as the first in a new APSAC series (Brassard, Hart, Baker, & Chiel, 2019); (d) multiple PM presentations and workshops at APSAC annual and regional meetings; (e) the formulation of a Psychological Maltreatment Alliance among APSAC, New York Foundling, and the School Psychology Program of Teachers College, Columbia University, to guide and promote advances in research, policy, education, and practice; and (f) cooperation among these same organizations, the Haruv Institute, the National Foundation to End Child Abuse and Neglect, and the International Institute for Child Rights and Development to convene a global child Psychological Maltreatment Summit (Indianapolis, October 27–29, 2019).

This edition of the *APSAC Advisor* joins that program of resources by providing five articles on PM. Our introductory article presenting context of meaning in regard to the nature of PM is joined by the following: "APSAC Definition of Psychological Maltreatment and U.S. State Statutes: Implications for Policy" by Amy Baker, "Psychological Maltreatment Is at Least as Harmful as Other Forms of Child Abuse and Neglect: A Research Review" by Marla Brassard, "Implications of Psychological Maltreatment for Universal Intervention" by Stuart Hart, and "Confronting Psychological Maltreatment in Integrated Primary Care" by Zoe Chiel and Christine Forivanti. These are relatively brief presentations that are intended to encourage reference to the much deeper treatment provided in the full APSAC PM publication series.

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The Essential Nature of Psychological Maltreatment

Child psychological maltreatment is a widespread condition that seriously damages human beings and their societies. The major forms of PM are terrorizing, spurning (active hostile rejection), isolating, corrupting/exploiting, emotional unresponsiveness (denying/withholding needed psychological/emotional nurturing, interaction, caring, and support), and medical/mental/health/educational neglect. In Table 1, section four, following the definition of PM, primary expressions of each major form of PM are presented. Substantial evidence indicates that PM is a common form of abuse and neglect. Its related consequences, now well established, are corruption, distortion, and limitation of the human development and behavior, short- and long-term. These outcomes and associates of PM are equal to and, in some cases, exceed the damage caused by all other forms of adversity. Arguably, a substantial proportion of persons requiring mental health services, substance abuse treatment, and incarceration and those who are a danger to themselves or others are suffering from psychological maltreatment or other conditions worsened by psychological maltreatment (Hart et al., 2017). Establishment of these facts, and appreciation in their regard, have grown significantly since the seminal 1983 International Conference on Psychological Abuse of Children (Office for the Study of the Psychological Rights of the Child [OSPRC], 1983), which was held to come to grips with serious concern about emotional abuse and neglect and how poorly it was understood and combated in previous decades (Garbarino, 1978; Garbarino, Guttmann, & Seeley, 1986; Brassard, Germain, & Hart, 1987). Although PM continues to be given relatively little attention in child protection work, the stage is set for transformations in child protection for which PM may be given and play a major role.

A Period of Opportunity

The growing interest in PM, generated recently particularly through APSAC-associated initiatives, should be advantageous in providing constructive influence to overcome the inadequate handling of PM issues in child protection work and dissatisfaction, generally, with the effectiveness of child protection

programs worldwide. Advances in child protection incorporation of PM have suffered from absence, unevenness, and lack of rigor and practical support in law and regulation, provision of community information and promotion of norms, investigation, evaluation, and intervention (Brassard, Hart, Baker, & Chiel, 2019). As for child protection more generally, the long-standing criticisms of its inadequacy in the United States and the world have stimulated strong concern and calls for change (for the United States, see, for example, Krugman, 1991; Melton, Thompson, & Small, 2002; National Foundation to End Child Abuse and Neglect website; and for the world, see United Nations General Assembly, 2006; Bissell, Boyden, Myers, & Cook, 2008).

A meaningful connection can be made between the findings that (a) traditional child protection efforts emphasizing posttrauma, reactive, narrow, and short-term corrective interventions are generally insufficient and (b) that they give little attention to psychological maltreatment. It has been suggested that PM may represent the keys in the dark that, if understood and appreciated, will illuminate the way forward to deal effectively with all forms of violence against children and toward a needed transformation of child protection (Hart & Glaser, 2011).

Michael Wald (Hart & Glaser, 2011) has convincingly argued that adequate progress in child protection will be substantially frustrated unless we establish child "well-being" as the superordinate goal of all associated efforts, the criterion against which the intentions and outcomes of each strategy, all programs, and all systems must be tested. Enlightened international guidance on the topics of health and development recognize this and champion holistic thriving beyond mere absence of pathology (see World Health Organization [WHO]'s definition of health, 1948; United Nations General Assembly, 1989, Articles 17, 27, 32). Missing in traditional child protection intervention is sufficient respect for the ultimate and essential criterion of holistic child well-being and for its central context for realization, the psycho-social domain. The United Nations Committee on the Rights of the Child (2011) has published *General Comment No. 13: The Right of the Child to Freedom From All Forms of Violence*, which provides specific support

for promoting "…a holistic approach … securing children's rights to survival, dignity, well-being, health, development…." (II.11.d.) and recognizes PM as it is framed here.

The Present State of Knowledge—A Brief Overview

PM is expressed in interpersonal relationships, occurring in shared physical space and in connected cyberspace. This psycho-social context is where the majority of promotive and degrading forces for well-being and quality of life are at play. The definition of *PM* and its detailed forms are presented here in Table 1.

PM derives its destructive power from its assault on human need fulfillment, which is also an important factor in all violence and maltreatment against children. There are three major **assumptions** about PM that we believe help to illuminate the nature of PM and guide its consideration in the broader context of child maltreatment, including related interventions:

1. While PM occurs in standalone (i.e., discrete) forms, it is also embedded in and associated with all other forms of maltreatment, their occurrence, and their outcomes. For example, being physically beaten or sexually assaulted by someone expected to care for you may be interpreted as deserved because of your failings or inherent flaws/inferiority, and this interpretation will be exacerbated if the perpetrator during or at other times has made degrading and corrupting statements about you.

2. The prevention and correction of other forms of maltreatment will continue to be less than adequate if the embedded and associated PM behaviors are not recognized and fully included in interventions; they represent critical components of the psycho-social experiential dynamics for all maltreatment forms that must be respected in primary prevention, risk reduction, and corrective safety-securing and therapeutic remedies.

3. The goal of preventing PM, which challenges traditional short-term, narrowly focused, posttrauma reactive intervention practices, can advance the transformation of child

protection toward primary prevention and good child caregiving to achieve child well-being, a transformation that has been widely recommended (see Brassard et al., 2019 for expanded coverage on all three assumptions).

PM is strongly associated with a large array of quite serious negative outcomes, with findings approaching proof of causation. As an example, adverse childhood experiences (ACEs) research has been reported as establishing robust evidence that child emotional abuse is *causally related* (the authors' term) to depressive disorders, anxiety disorders, suicide attempts, drug use, and sexually transmitted diseases/sexually risky behavior, approximately doubling the risk for adverse mental health outcomes when mediating variables are taken into consideration (Anda, Butchart, Felitti, & Brown, 2010; Norman et al., 2012).

In the *Psychological Maltreatment* monograph (Brassard et al., 2019), you will find a thorough analysis of the related knowledge base organized in the five areas of harm derived from the definition of *emotional disturbance* in the United States (federal) Individuals with Disabilities Act as Amended (IDEAA), commonly known as IDEAA (See code of federal regulations; https://sites.ed.gov/idea/). The five areas of harm are as follows: *problems of intrapersonal (within the individual) thoughts, feelings, and behaviors; emotional problems and symptoms; social competency problems and anti-social functioning; learning problems and behavioral problems; and physical health problems/adverse biological changes* (supportive research includes but is not limited to the following: Abajobir, Kisely, Williams, Strathearn, & Najman, 2017; Altamimi, Alumuneef, Albuhairan, & Saleheen, 2017; Rosenkranz, Muller, & Henderson, 2012; Spinhoven et al., 2010; Taillieu, Brownridge, Sareen, & Afifi, 2016; Van Harmelen et al., 2014; Varese et al., 2012).

Estimates of the prevalence of psychological maltreatment have been found to range widely, depending on definitions, procedures, and sources used. Although informant-based data tend to underestimate, and self-report studies may overestimate prevalence (perhaps due to people labeling isolated incidents as abuse, rather than a chronic pattern of maladaptive interactions), there

Table 1. Psychological Maltreatment Definition and Forms.

Psychological maltreatment is defined as *a repeated pattern or extreme incident(s) of caretaker behavior* that thwart the child's basic psychological needs (e.g., safety, socialization, emotional and social support, cognitive stimulation, respect) and convey a child is worthless, defective, damaged goods, unloved, unwanted, endangered, primarily useful in meeting another's needs, and/or expendable. Its subtypes and their forms follow.

SPURNING embodies verbal and nonverbal caregiver acts that reject and degrade a child, including the following:
1. belittling, degrading, and other nonphysical forms of hostile or rejecting treatment;
2. shaming and/or ridiculing the child, including the child's physical, psychological, and behavioral characteristics, such as showing normal emotions of affection, grief, anger, or fear;
3. consistently singling out one child to criticize and punish, to perform most of the household chores, and/or to receive fewer family assets or resources (e.g., food, clothing);
4. humiliating, especially when in public;
5. any other physical abuse, physical neglect, or sexual abuse that also involves spurning the child, such as telling the child that he or she is dirty or damaged due to or deserving sexual abuse; berating the child while beating him or her; telling the child that he or she does not deserve to have basic needs met.

TERRORIZING is caregiver behavior that threatens or is likely to physically hurt, kill, abandon, or place the child or child's loved ones or objects in recognizably dangerous or frightening situations. Terrorizing includes the following:
1. subjecting a child to frightening or chaotic circumstances;
2. placing a child in recognizably dangerous situations;
3. threatening to abandon or abandoning the child;
4. setting rigid or unrealistic expectations with threat of loss, harm, or danger if they are not met;
5. threatening or perpetrating violence (which is also physical abuse) against the child;
6. threatening or perpetrating violence against a child's loved ones, pets, or objects, including domestic/intimate partner violence observable by the child;
7. preventing a child from having access to needed food, light, water, or access to the toilet;
8. preventing a child from needed sleep, relaxing, or resting;
9. any other acts of physical abuse, physical neglect, or sexual abuse that also involve terrorizing the child (e.g., forced intercourse; beatings and mutilations).

EXPLOITING/CORRUPTING are caregiver acts that encourage the child to develop inappropriate behaviors and attitudes (i.e., self-destructive, antisocial, criminal, deviant, or other maladaptive behaviors). While these two categories are conceptually distinct, they are not empirically distinguishable and, thus, are described as a combined subtype. Exploiting/corrupting includes the following:
1. modeling, permitting, or encouraging antisocial behavior (e.g., prostitution, performance in pornography, criminal activities, substance abuse, violence to or corruption of others);
2. modeling, permitting, or encouraging betraying the trust of or being cruel to another person;
3. modeling, permitting, or encouraging developmentally inappropriate behavior (e.g., parentification, adultification, infantilization);
4. subjecting the observing child to belittling, degrading, and other forms of hostile or rejecting treatment of those in significant relationships with the child such as parents, siblings, and extended kin;

Continued on next page...

Table 1. Psychological Maltreatment Definition and Forms.

5. coercing the child's submission through extreme over-involvement, intrusiveness, or dominance, allowing little or no opportunity or support for child's views, feelings, and wishes; forcing the child to live the parent's dreams, manipulating or micromanaging the child's life (e.g., inducing guilt, fostering anxiety, threatening withdrawal of love, placing a child in a double bind in which the child is doomed to fail or disappoint, or disorienting the child by stating something is true (or false) when it patently is not);

6. restricting, interfering with, or directly undermining the child's development in cognitive, social, affective/emotional, physical, or cognitive/volitional (i.e., acting from emotion and thinking; choosing, exercising will) domains, including Caregiver Fabricated Illness also known as medical child abuse;

7. any other physical abuse, physical neglect, or sexual abuse that also involves exploiting/corrupting the child (such as incest and sexual grooming of the child).

EMOTIONAL UNRESPONSIVENESS (ignoring) embodies caregiver acts that ignore the child's attempts and needs to interact (failing to express affection, caring, and love for the child) and showing little or no emotion in interactions with the child. It includes the following:

1. being detached and uninvolved;

2. interacting only when absolutely necessary;

3. failing to express warmth, affection, caring, and love for the child;

4. being emotionally detached and inattentive to the child's needs to be safe and secure, such as failing to detect a child's victimization by others or failing to attend to the child's basic needs;

5. any other physical abuse, physical neglect, or sexual abuse that also involves emotional unresponsiveness.

ISOLATING embodies caregiver acts that consistently and unreasonably deny the child opportunities to meet needs for interacting/communicating with peers or adults inside or outside the home. Isolating includes the following:

1. confining the child or placing unreasonable limitations on the child's freedom of movement within his or her environment;

2. placing unreasonable limitations or restrictions on social interactions with family members, peers, or adults in the community;[1]

3. any other physical abuse, physical neglect, or sexual abuse that also involves isolating the child, such as preventing the child from social interaction with peers because of the poor physical condition or interpersonal climate of the home.

MENTAL HEALTH, MEDICAL, AND EDUCATIONAL NEGLECT embodies caregiver acts that ignore, refuse to allow, or fail to provide the necessary treatment for the mental health, medical, and educational problems or needs of the child. This includes the following:

1. ignoring the need for, failing, or refusing to allow or provide treatment for serious emotional/behavioral problems or needs of the child;

2. ignoring the need for, failing, or refusing to allow or provide treatment for serious physical health problems or needs of the child;

3. ignoring the need for, failing, or refusing or allow or provide treatment for services for serious educational problems or needs of the child;

4. any other physical abuse, physical neglect, or sexual abuse that also involve mental health, medical, or educational neglect of the child.

Original Source: Hart, S. N., & Brassard, M. R. (1991/ 2001). **Revised Source:** Hart, Brassard, Baker, & Chiel (2019).

Note 1: Caregiver abandonment of a child is one of the most severe forms of PM. While it is specifically identified as a type of terrorizing in this document, it also embodies significant components of emotional unresponsiveness, spurning, and isolating.

is a clear problem with the under-identification of PM through child protection agencies and in the public eye. In light of discrepancies in definitions and samples used across studies as well as probable under-reporting according to recent analyses of available sources (Brassard et al., 2019), we continue to judge the prevalence rates estimated from *Psychological Maltreatment of Children: APSAC Study Guides 4* (Binggeli, Hart, & Brassard, 2001) to be relevant and probably the best available. Therefore, it is reasonable to estimate that between 10% and 30% of community samples experience moderate levels of PM in their lifetime and 10%–15% of all people (community and clinical samples) have experienced the more severe and chronic forms of this maltreatment (p. 51). When prevalence is considered in light of guiding assumption 1, above list, this estimate must be judged as quite conservative, accepting that PM is embedded in or closely associated with most if not all instances of physical and sexual abuse and neglect.

A variety of theories help to clarify the nature of PM and possibilities for intervention. In our perspective, human needs theory (Maslow, 1970; Ryan & Deci, 2000; Sheldon, Elliot, Kim, & Kasser, 2001) holds a central explanatory and guiding position. PM derives its substantial destructive power from the fact that it is an assault on human need fulfillment (e.g., terrorizing opposes safety, emotional unresponsiveness and isolation oppose love and belonging/affiliation, corrupting/distorting and spurning oppose worth and esteem/efficacy). Other theoretical positions are compatible with and complement human needs theory in this regard. These include, but are not limited to, psycho-social stage theory for which interpersonal trust and development support are central (Erikson, 1993; Erikson & Erikson, 1998); attachment theory, in which the goal of secure attachment requires sensitive, responsive caring (Ainsworth, 1969, 1989; Main, 1999; Sroufe, 1979); interpersonal acceptance-rejection theory, which explains the destructive nature of psycho-social rejection (Rohner & Rohner, 1980); and learned helplessness, in which esteem and agency are corrupted (Seligman, 1972); Cole & Coyne, 1977; Hiroto & Seligman, 1975; Peterson & Park, 1998). PM's nature is illuminated by each of these theoretical orientations (Brassard et al., 2019).

Effective intervention for PM is arguably a gateway to more successful intervention for all forms of violence against children. PM challenges attempts to intervene primarily by condemning and eliminating behaviors. This is true for a number of reasons, including but not limited to the following: PM is part of habit-formed short-sighted human behavior patterns to meet one's own needs; it approaches ubiquity in some contexts; it is expressed in a multitude of forms, patterns, and magnitudes beyond detailing; and it appears to be particularly destructive in less blatant or more subtle, frequently occurring forms that act like small-dose arsenic or lead poisoning of human relationships and personal integrity that accumulates deceivingly to toxic levels. Efforts to prevent and reduce PM and its harm require attention to the essential nature of interpersonal relations, associated attitudes, and behavioral expressions in the psycho-social domain across the full developmental period of the child. A proactive developmental approach that gives first order priority to promotion of child well-being from birth on through positive, caring interpersonal relations is gaining support worldwide (see United Nations Committee on Rights of the Child, 2011; Hart, Lee, & Wernham, 2011). Promotion of child well-being deserves particular emphasis. It demands a holistic approach and reduces the likelihood of helping that hurts (i.e., iatrogenics), produced through narrowly framed and fragmented interventions. Adherence to this priority is needed, should be applied, and is possible across the three major tiers of intervention: primary prevention, risk reduction, and correction. Inclusion of PM consideration in all aspects of child protection work (e.g., intake, investigation, determination, and intervention), infusion of child rights and public health approaches (Brassard et al., 2019), and the application of relational interventions (Toth, Gravener-Davis, Guild, & Cicchetti, 2013) have been recommended to achieve related advances. (In this *Advisor*, see further coverage in Stuart Hart, "Implications of Psychological Maltreatment for Universal Intervention.")

Concluding Comments

The central messages of this article in regard to psychological maltreatment are as follows: (1) psychological maltreatment is a serious threat to the health and well-being of child victims, their families,

and communities, (2) this issue has historically been given far too little attention, (3) PM challenges traditional reactive intervention practices and can be a strong catalytic agent for transformation of all child maltreatment intervention toward proactive primary prevention, including promotion of child well-being, and (4) it should be included specifically in the designs, policies, and practices of prevention, risk reduction, and correction for all forms of child maltreatment through child health, development, and protection services. As stated at the outset, this issue of the *APSAC Advisor* provides clarification of the nature of psychological maltreatment and guidance toward effective intervention in a complementary series of articles that join a program of other APSAC publications offering breadth and depth coverage on the topic.

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Psychological Maltreatment

Reported Rates of Psychological Maltreatment and U.S. State Statutes: Implications for Policy

Amy J. L. Baker, PhD

Key words: psychological maltreatment, emotional abuse, emotional neglect, state statutes, child maltreatment definitions

Psychological maltreatment (PM) was legally introduced as a form of child maltreatment in the 1974 Child Abuse Prevention and Treatment Act (CAPTA) with the term *mental injury*. The current version of CAPTA (2010) uses the term *emotional harm* but provides no further definition of PM. One of the intentions of the original CAPTA legislation was to encourage states to create child abuse and neglect reporting laws, using their own definitions of the various types of child maltreatment (Pecora et al., 2010). Previous reviews of state statutes have identified a lack of consistent definition of PM and have found tremendous variation across states in rates of reported PM (Baker, 2009; Hamarman, Pope, & Czaja, 2002; Shpiegel, Simmel, & Huang, 2013). Most recently, Baker and Brassard (n.d.) aimed to build on these earlier research studies by analyzing 2014 NCANDS data (administrative data provided to the Children's Bureau by state child protection agencies) and state statutes with respect to rates and definitions of PM (DHHS, 2016).

Summary of Results

With respect to rates of PM, it was found that 26 states had fewer than 1 child victim of PM per 10,000 children, 17 states had rates between 1 and 20 child victims of PM per 10,000 children, and nine states had rates of over 30 child victims of PM per 10,000 children. The difference between the state with the lowest rate (0, many states) and the state with the

highest rate (52, Maine) was calculated as 520-fold. The difference in rates of lowest and highest was 30-fold for physical abuse, 20-fold for sexual abuse, and 500-fold for neglect. Of the 10 states with the highest rates of PM per 10,000 children in 1998, five remained in the top 10 in 2014. Of the 10 states with the lowest rates of PM in 1998, only two remained in the lowest ranking.

In terms of the wording of state statutes, all but six mentioned PM, primarily referring to it as "mental injury," with many statutes offering no or only a vague definition. Analyses examining associations between the wording of the statutes and rates of PM found that there was no statistically significant association between rates of PM and whether some form of psychological maltreatment was mentioned in the statute, whether PM was defined in the statute, or whether specific caregiver behaviors were identified (only six statutes). There was a statistically significant effect for whether harm had to be established to have a finding of PM. When this was included in the statute, rates of PM were significantly lower. Variation in state statutes as assessed in this study accounted for only a small percentage of the overall variation in rates of PM.

Discussion and Recommendations

There continues to be tremendous variation across states in reported rates of PM per 10,000 children. We concur with Shpiegel and colleagues (2013) that actual differences are not likely to exist, at least not

to the extent found in the data. It is not plausible that in several states no child was subjected to PM. As Shpiegel et al. (2013) noted, variation found in reported rates of PM in their data and earlier data suggests that "the existence of true differences is an unlikely explanation. There is no reason to suspect that emotional maltreatment is a regional phenomenon" (p. 639). This is supported by research that has not found associations between state demographics and rates of PM (Black, Smith Slep, & Heyman, 2001).

Only a small amount of the tremendous variation in rates of PM was found to be associated with variation in the wording of state statutes. It is clear that other factors are at work and should be explored and tested in future research. Two avenues to explore are, first, elements of the state statutes unrelated to the definition of PM that could affect which cases are called in and which are substantiated. Such factors might include what is the time frame in which reports must be investigated, who are mandated reporters, how are immunity and confidentiality handled, whether reports are made to a centralized entity or local entity, and so forth. These are factors that are likely to vary across states and, therefore, may account for differences in rates of PM by facilitating or discouraging such reports. The second avenue to consider is likely variation in policy and practice (as opposed to statute), including what questions are asked of a reporter during the initial screening of cases, whether screeners must ask about psychological maltreatment regardless of the impetus of the call, what risk assessments are utilized, caseload of child protection workers, and unspoken pressures to identify cases or not. These factors most likely vary within as well as across states. *It is recommended that future research aim to identify and test these and related variables.*

Only a handful of state statutes included a specification of the types of caregiver behaviors that described or caused PM. This is a notable shortcoming. If the state statutes (and subsequent training) included specific caregiver behaviors, there might be increased awareness among child protection workers and others concerned with the well-being and protection of children about the types of behaviors that cause emotional harm to children. That is, if the statutes

and training alerted reporters to the specific kinds of caregiver behaviors that constitute PM, reporters would be better able to recognize it and would be able to act on their concerns. *It is recommended that statutes be amended to include this information.*

About two thirds of the statutes required determination of harm having been experienced by the child in order to have a finding of PM, and this factor was associated with lower rates of PM. However, there is probably variation in how harm is defined and how it needs to be assessed and established for a finding to occur. *It is recommended that this issue be addressed in future research.* To begin with, the statutes and the content of the mandated reporter trainings could be examined for a more fine-grained analysis of the type of harm required and the method for establishing that harm has occurred. In addition, research could explore the barriers experienced by mandated reporters and child abuse investigators with respect to establishing harm.

No state statutes utilize definitions of PM that are consistent with any of the prevailing research definitions. These research definitions include the U.S. National Incidence Study of Child Abuse and Neglect (NIS-4; Sedlak et al., 2010); Canadian Incidence Study on Reported Child Abuse and Neglect (CIS; Potter, Nasserie, & Tonmyr, 2015), the Maltreatment Classification System (MCS; Barnett, Manly, & Cicchetti, 1993; MMCS, English and the Longscan Investigators, 1997), the APSAC definition (Hart & Brassard, 1991, 2001; Hart, Brassard, Baker, & Chiel, 2017; Trickett, Mennen, Kim, & Sang, 2009), ISPCAN Child Abuse Screening Tools developed for international use (ICAST; Runyan, Dunne, & Zolotor, 2009), and the Family Maltreatment Diagnostic Criteria developed for the U.S. Department of Defense (Slep & Heyman, 2006; Heyman & Slep, 2006, 2009). These have been used in research (e.g., NIS-4, CIS, MCS, APSAC, ICAST) or routine child welfare practice (U.S. Department of Defense) with a high degree of reliability. The use of reliable research definitions may be why rates of PM are so much higher in the NIS-4 data—which defines PM as caretaker behaviors (between 20 and 24 per 10,000 for emotional abuse and between 49 and 159 for emotional neglect, depending on whether the harm or

risk of harm standard is used; Sedlak et al., 2010). *An important next step for the field would be to identify the advantages and disadvantages of different definitional systems.*

An apparent disconnect exists between state statutes and NCANDS data. For example, some states have no mention of PM in their statute and yet, according to NCANDS, have reported cases. *Clarifying the coding of PM in NCANDS would be helpful and is recommended.*

In all but 16 states, statutes regarding child maltreatment were found to have been updated to include at least one of four forms of abuse or neglect that was not relevant or in the public awareness at the time of the original CAPTA legislation, or both: (1) sexual/human trafficking, (2) exposing a child to the production of drugs, (3) giving birth to a baby addicted to drugs/alcohol or giving a child drugs/alcohol, and (4) engaging in female genital mutilation. This suggests that state legislators are willing under certain circumstances to modify the definitions of child abuse and neglect.

The definitions of PM remained sparse and static by comparison. The fact that the definitions of mental injury are so brief and somewhat outdated suggests that there hasn't yet been a perceived need to ensure the adequacy of this portion of the state statue codebook, perhaps because PM is not perceived to be as harmful as other forms of maltreatment. However, the research evidence now exists to support the understanding that PM occurs both alone as well as with other forms of child maltreatment. When it occurs alone, it is at least as harmful as other forms occurring alone (e.g., Felitti et al., 1998; Vachon, Krueger, Rogosch, & Cicchetti (2015) and when

combined with other forms can exacerbate their negative consequences (e.g., Berzenski & Yates, 2011; Vashon et al., 2015).

Therefore, the principal recommendation based on this analysis of state statutes combined with 2014 NCANDS data is for experts to develop and for states to adopt a consensus statute definition of PM. It is important to note that the study of PM was originally hampered by lack of consistent definitions (Brassard & Donovan, 2006). However, the field has moved toward consensus that PM should be defined as caregiver behaviors, and there is considerable concordance among the most widely used definitional systems (Hart et al., 2017).

This will set off a need for updated mandated reporter training to include information about what PM is, how it harms children, and what the risk factors of PM are. Ideally, this could also result in more systematic inclusion of information about PM in all existing and future training on child maltreatment, whether it is for graduate courses for social workers, psychologists, and other helping professionals, for pediatricians, parent educators, school personnel, or those involved in the family law field. Until PM is understood and accurately identified and reported by all who interface with families, the promotion of children's well-being cannot fully be achieved.

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Is Psychological Maltreatment as Harmful as Other Forms of Child Abuse and Neglect? A Research Review

Marla R. Brassard, PhD

Key words: psychological maltreatment, emotional abuse, emotional neglect, adverse childhood events, maltreatment as a causal factor in psychopathology

United States state statutes demonstrate a clear hierarchy in how harmful the different forms of child maltreatment are perceived (see Baker, 2019). Child sexual abuse is in all state statutes, is reported to child protective services (CPS) and the police, is assumed without need for evidence when there is harm to the child, and is a felony in which perpetrators risk conviction. Psychological maltreatment (PM), also known as emotional abuse and neglect or mental cruelty, is treated very differently across states. Six states do not include it in their statutes, and over half report few or no identified cases in the National Child Abuse and Neglect Data System (U.S. Department of Health & Human Services [USDHHS], 2016). In those statutes that do report cases, two thirds require evidence of emotional harm to substantiate a case (Baker, 2019; Baker & Brassard, 2019).

Research does not support this prioritizing of one form of child maltreatment over another. This article presents the evidence (briefly) for considering PM the equal in harm to child sexual abuse, physical abuse, and physical neglect and potentially more harmful in causing depression, lifelong suicide risk, and thinking disorders. A longer presentation is available in the *APSAC Monograph on Psychological Maltreatment* (Brassard, Hart, Baker, & Chiel, 2019).

The publication of the Adverse Childhood Experiences Study (ACE; Felitti et al., 1998) of 13,000+ adult members of the Kaiser Health Plan in San Diego, and subsequent publications by this group, have had immense influence on how seriously child maltreatment (and PM in particular) is taken by scholars, the health care system, and policy makers in the United States and around the world. Their original work tied the retrospective report of four forms of child maltreatment (emotional, sexual, physical abuse, and battered mother) and three characteristics of household dysfunction (household substance abuse, household mental illness, incarcerated household member) to many of the leading causes of death in adults (e.g., ischemic heart disease, cancer), promiscuity, unintended pregnancy, sexually transmitted diseases, smoking, early smoking onset, alcoholism, drug abuse, depression, and suicide attempts (Anda et al., 1999; Dube et al., 2001; Felitti et al., 1998; Hillis, Anda, Felitti, Nordenberg, & Marchbanks, 2000). Each of the ACEs conferred increased risk, and there was a dose-reponse relationship in that the more adverse childhood events reported the greater the likelihood of experiencing an adverse health outcome, particularly for those reporting four or more adverse childhood events, who were more at risk for each negative outcome and more different types of negative outcomes. They replicated their findings in four cohorts with birth dates back to 1900, showing that the ACE-adverse outcomes relationship was generally impervious to secular changes (Dube et al., 2003). The ACE questionnaire and adaptations of it have been used in hundreds of studies around the world, replicating the original findings (e.g., Bellis, Hughes, Leckenby, Perkins,

& Lowey, 2014; Campbell, Walker, & Egede, 2016; Kessler et. al, 2010).

Of importance in regard to psychological maltreatment is that emotional abuse, assessed on the ACE questionnaire with from two to three items assessing spurning and terrorizing (e.g., "How often did a parent, stepparent, or adult in the home swear at you, insult you, or put you down"), held its own as an equivalently strong ACE in terms of predicting health adverse outcomes (Anda et al., 1999). It had the highest odds ratio among the ACEs "for both a lifetime history of depressive disorders and recent depressive disorders" (Chapman et al., 2004, p. 221) as well as lifetime attempted suicide (Dube et al., 2001), and it was one of the three highest relative risk ratios for unintended pregnancy (Dietz et al., 1999). When treated as an emotional climate factor, emotional abuse interacted significantly to enhance risk with other forms of child maltreatment and increased risk as a sole variable (Edwards, Holden, Felitti, & Anda, 2003).

On the one hand, the ACE and ACE-related studies have brought attention to PM as an important adversity, but on the other hand the methodology of using retrospective reports, as opposed to prospective identification of child maltreatment, is controversial and may bias findings. Prospective measures of childhood maltreatment, such CPS records and parental interview in childhood, are weakly correlated with later recall of maltreatment by the same individuals (see Baldwin, Reuben, Newbury, & Danese, 2019, for a recent meta-analysis). This has led one leading researcher, Widom (2019), to question the use of retrospective reports altogether:

> From a scientific perspective, cross-sectional studies based on retrospective reports cannot demonstrate that childhood adversities cause particular outcomes. From a clinical perspective, these new findings do not negate the importance of listening to what a patient says, but they suggest that caution should be used in assuming that these retrospective reports accurately represent experiences, rather than perceptions, interpretations, or existential recollections. (p. 568)

Even though prospective reports are generally considered more valid, the problems with bias in CPS records are also well known: children who were identified likely experienced more severe maltreatment than those not identified, those reported to CPS are only a small percentage of those maltreated, PM is still not identified in many jurisdictions, and cases reported are more often from low-income families, who are more heavily surveilled by government employees (Baldwin, Reuben, et al., 2019; Kobulsky, Kepple, & Jedwab, 2018; Newbury et al., 2018). For these reasons, retrospective accounts cannot be completely disregarded. If valid, both types of reports should relate to increased psychopathology and other adverse outcomes in the same individuals, whether assessed with self-reports or other objective measures. Some studies testing these hypotheses have found similar outcomes for both types of reports (e.g., Baldwin, Reuben, et al., 2019; Tajima, Herrenkohl, Huang, & Whitney, 2004), while others have found them only for prospective reports (Osborn & Widom, 2019). Both types of reports under identify victims. For example, Baldwin, Reuben, et al. (2019) found that more than half of prospective victims did not report having been maltreated retrospectively, which is similar to the percentage of individuals reporting maltreatment retrospectively who did not have a prospective report. What is important is that the research and clinical communities need to be aware that retrospective recall often does not match contemporary evidence of maltreatment.

Does Child Maltreatment Contribute to Adverse Events in a Causal Fashion?

The ACE authors have argued forcefully that child maltreatment (and other forms of childhood trauma) is *causally* related to adverse outcomes across the lifespan, drawing on converging evidence from epidemiology, neurobiology, and prospective studies that carefully assessed all forms of maltreatment in childhood (through parental reports, observations over time, CPS reports, or substantiation) and adverse events in later life (Anda, Felitti, & Bremner, 2006). The assumption that maltreatment creates adverse outcomes and must be prevented, stopped when identified, and treated underlies our field. However,

this assumption of causality is controversial among scientists and still a work in progress (Moffitt & the Klaus-Grawe 2012 Think Tank, 2013).

Criteria for establishing causation include the strength and consistency of a relationship between a causal variable and outcome, specificity of effect, a clear temporal sequence of experienced condition and adverse effect, a dose-response curve, plausibility, well-developed theoretical models of the mechanisms involved, and the ruling out of all other explanations (Hardy et al., 2016; Hill, 2015; Schaefer et al., 2017). Most of these criteria have been met except for the ruling out of all other explanations. Child maltreatment co-occurs with many other risk factors, both environmental (e.g., poverty) and genetic (e.g., impulsivity) that increase exposure to adverse environmental events. Experimental evidence in nonhuman animals demonstrates that high levels of stress in childhood cause adverse changes in the brain and body (e.g., telomere erosion, inflammation). This work is highly suggestive that humans would respond in the same way, but such studies are unethical in humans (some would argue in nonhumans as well), leaving researchers with the option of demonstrating causality through inference from observational prospective studies and possibly experimental clinical treatments that result in significant psychological, behavioral, and biological changes in a healthier direction (Moffitt & the Klaus-Grawe 2012 Think Tank, 2013).

Schaefer et al. (2017) conducted a prospective study offering some of the strongest observational evidence for causality between childhood victimization (including PM) and adult psychopathology. They used the genetically informed Environmental Risk (E-Risk) Longitudinal Twin Study of 2,232 English and Welch same-sex twins born 1994–1995 and chosen to be representative of United Kingdom newborns in 1990 in order to test the hypothesis that victimization in adolescence, based on young adult report, would predict psychopathology at age 18, controlling for childhood victimization (carefully assessed on four occasions). *Psychopathology* was defined as mother- and teacher-rated internalizing, externalizing, and thought-disorder scores on the Achenbach System of Empirically-Based Assessment

(ASEBA; Achenbach, 2009). Victimization in adolescence *did* predict increases in psychopathology controlling for pre-existing psychopathology at earlier ages. All types of victimization increased the risk of all types of psychopathology in a dose-response relationship. Child maltreatment was significantly more predictive of adverse outcomes than the other types of victimization (e.g., Internet/phone, crime). There were no consistent patterns of sex differences in the relationship between victimization and psychopathology.

The E-Risk authors used multi-informants about victimization history (self, mother, co-twin), and so the source of information did not bias reports of victimization and their design allowed the researchers to examine the degree to which genes influenced exposure to victimization (and thus psychopathology) as opposed to victimization causing psychopathology. While monozygotic (MZ or identical) twins were more similar in their victimization experiences than dizygotic (DZ) twins, which indicates genetic effects on environmental exposures, both MZ and DZ twins discordant for victimization differed significantly in their degree of psychopathology at age 18. The exposed twin had more psychopathology in young adulthood. This indicated that the association between victimization and psychopathology "could not be fully explained by shared family-wide environmental factors or genetic factors, suggesting the possibility of an environmentally mediated pathway from greater victimization exposure in adolescence to more psychiatric symptoms in early adulthood" (p. 363). Because there were too few twins discordant for victimization, they could not test for which specific types of victimization predicted early-adult psychopathology, independent of shared family-wide and genetic risk factors. The authors concluded that their findings "approached causal inference by systematically ruling out noncausal explanations" (p. 352). An accumulation of such studies is needed to establish causality.

Are All Forms of Child Maltreatment Equivalently and Nonspecifically Harmful?

Recently there has been a call to acknowledge that all

forms of CM are equivalently harmful and nonspecific in the types of psychopathology that they are related to or seem to causally promote. There is some research to support this position, but it is not conclusive. Illustrative of this call is the E-Risk article by Schaefer et al. (2017) reviewed above. Both childhood and adolescent victimization contributed independently and cumulatively to mental health at age 18. Internalizing, externalizing, and thought problems were all elevated in a dose-response relationship to total victimization across both developmental periods.

Vachon, Krueger, Rogosch, and Cicchetti (2015) is a second example of a large, careful study concluding that all forms of child maltreatment are equivalent in harm and nonspecific. This study used 27 years of data from the Mt. Hope summer camps (years 1986–2012). Participants were half male, 60% African American, and all in their first year attending the summer camp. Forms of maltreatment were coded with the Modified Maltreatment Classification System (CPS records, all child welfare records, maternal interview) and assessment of harm was based on comparing maltreated children (substantiated by CPS) with not maltreated children matched on SES. Psychopathology and social competence were assessed with peer reports, counselor reports, and self-reports from the week at summer camp. Emotional abuse, neglect, and physical abuse were highly correlated $r = .82$; therefore, they had to be treated as a common factor in analyses. The authors found that all forms of child maltreatment caused significant harm and equivalent harm. Effects of child maltreatment were general (i.e., not specific in terms of psychopathology). There was no moderation of effects by sex or race/ethnicity. There was a strong dose-response effect: the presence of any type of child maltreatment, the more variety of child maltreatment, the more events of child maltreatment, and the more severe the child maltreatment the more psychopathology. The researchers concluded that

because different types of child abuse have equivalent, broad, and universal effects, effective treatments for maltreatment of any sort are likely to have comprehensive psychological benefits. Population-level prevention and intervention strategies should emphasize emotional abuse, which occurs with high frequency but is less punishable than

other types of child maltreatment. (p. 1135)

While both of these studies found equivalent and nonspecific harm in relationship to child maltreatment exposure, there are aspects of each study's design that limited its ability to identify unique effects from experiencing each form of maltreatment. The E-Risk study had too few twins discordant for victimization to test for which specific types of victimization predicted early-adult psychopathology independent of shared family-wide and genetic risk factors. Also, the sample was living in the community with their families and thus represented a healthier group than children being raised in foster care or institutions. The Mt. Hope study had a low-SES, CPS-substantiated sample of children who had typically experienced multiple forms of abuse and neglect. This demographic made it impossible to tease out the unique experience of one form of maltreatment from another. For example, only 14 children in their sample had experienced only sexual abuse; however, 143 had experienced sexual abuse and one or more other forms of child abuse and neglect. Only 117 of the 730 children experiencing emotional maltreatment had experienced uniquely that form of maltreatment with no other forms present.

Unique Relationships Between PM and Adverse Events

All forms of child maltreatment are significantly related to adverse outcomes. All forms of child maltreatment are related to increases in the risk of psychopathology in clear dose-response fashion, with multiple forms of maltreatment exposure having an even greater effect size than the component sum would predict (e.g., Teicher, Samson, Polcari, & McGreenery, 2006). But, even with the common adversity of poor treatment by caregivers, there is strong evidence of unique effects from the form of maltreatment children experience. A sample of these findings relative to PM is described in the next section. Before presenting these studies, it is important to acknowledge that many factors influence the specific effects of PM (or any other form of child maltreatment) on a given child. Children's age or their developmental stage may make them more or less vulnerable to PM. Children's genes influence how sensitive they are to the psychosocial environment (good *and* bad), which makes them more or less likely to suffer harm as a result of PM than their siblings or other children (Belsky & Pluess, 2013).

Children also differ in their environments, which may mitigate (e.g., caring and competent teachers; Lynch & Cicchetti, 1992) or intensify the effects of PM (e.g., violent neighborhoods).

The definition of *emotional disturbance* in the United States (federal) Individuals with Disabilities Act as Amended (IDEAA, 2004; United States Congress [USC], 2004) is used to organize research related to the adverse impact of the forms of PM described in Table 1 of this issue of the *Advisor* (Hart & Brassard, 2019). This IDEAA definition is brief and yet incorporates psychological criteria for major mental disorders and interpersonal, cognitive, emotional, and behavior problems (American Psychiatric Association, 2013). The IDEAA framework for harm includes five categories. Representative research findings are provided under each category of harm to illustrate the range and quality of research support for the form of psychological maltreatment that falls within each category:

Problems of Intrapersonal (Within the Individual) Thoughts, Feelings, and Behaviors

The relationship between PM and depression and negative cognitive style is very strong. This is true in studies that assess maltreatment prospectively and those that assess it cross-sectionally or retrospectively. For example, the Adverse Childhood Experiences Study (ACEs; Chapman et al., 2004), a retrospective study, found that "childhood emotional abuse posed the greatest risk of the ACEs for both a lifetime history of depressive disorders and recent depressive disorders." A number of studies have looked at negative cognitive styles (e.g., pessimism) as a precursor to depression. In an example, van Harmelen, de Jong, Glashouwer, Spinhoven, Penninx, and Elzinga (2010) found that child abuse was significantly associated with negative explicit and automatic self-associations using the Netherlands Study of Depression and Anxiety (N = 2,981). Child emotional maltreatment had the strongest significant link, when compared with child sexual and physical abuse, and mediated the relationship between child abuse and negative self-association. The Dutch group also found that "childhood adversities" (which included maltreatment) predicted affective disorders

significantly better than lifetime negative events (Spinhoven et al., 2010) after controlling for lifetime DSM-IV diagnoses and clustering of adversities. Emotional neglect was statistically the most powerful predictive form of the childhood adversities and was associated specifically with diagnoses of depressive disorder and social phobia. Moreover, Paterniti, Sterner, Caldwell, and Bisserbe (2017) found that childhood emotional neglect predicted depression recurrence in a followed sample of patients (N = 238) at a mood disorders clinic.

Norman et al. (2012) performed a systematic review and exhaustive meta-analysis of the international literature on the long-term health consequences of nonsexual forms of child maltreatment. The authors included only those studies that measured each form of maltreatment separately. They found robust evidence that child emotional abuse is *causally related* to depressive disorders, anxiety disorders, suicide attempts, drug use, and sexually transmitted diseases/ sexually risky behavior, approximately doubling the risk for adverse mental health outcomes when mediating variables are taken into consideration. Notably, most of the studies they reviewed used a cross sectional or retrospective methodology to assess child maltreatment.

Fortunately, there are a number of prospective studies that assess child maltreatment through parent report, observation, CPS records or a combination of these methods and then follow children longitudinally. Many of these have found similar conclusions about the relationship between PM and internalizing disorders. For example, Spinazzola et al. (2014) used a sample of 5,616 children (average age 11–12 years) with a lifetime history of exposure to maltreatment from the National Child Traumatic Stress Network Core Data Set to explore the effects of maltreatment on psychopathology. They found that children with emotional abuse and neglect exhibited significantly greater baseline problems in the area of internalizing disorders than the other forms of maltreatment, separately and combined. It was the strongest and the most consistent predictor of depression, generalized anxiety disorder, social anxiety disorders, and attachment problems.

McGee, Wolfe, and Wilson (1997), using a Canadian CPS sample of 160 adolescents, found that youth who had been substantiated for PM by CPS in childhood and who reported PM on interview as a teen had the greatest levels of internalizing problems in the sample of maltreated youth. This relationship held even when controlling for demographic variables and negative life events. The Lehigh Longitudinal Study found that only severe emotional abuse in childhood (and not sexual or physical abuse) had direct effects on adult outcomes classes for substance misuse and depression. Children exposed to emotional abuse were significantly more likely to have comorbid substance misuse and internalizing problems into their fourth decade even when controlling for depression and substance misuse in adolescence (Skinner et al., 2016). Vachon et al. (2015) found that, similarly to other forms of maltreatment in a CPS substantiated sample, PM predicted a significant increase in the likelihood of internalizing problems compared with nonmaltreated LSES peers.

There is a large literature linking child maltreatment (in addition to depression and anxiety) with suicidality; some evidence suggests that this relationship is likely causal. Using the E-Risk sample, Baldwin, Arseneault et al. (2019) found that each additional exposure to victimization doubled the odds that "adolescents would experience suicidal thoughts and self-harm and tripled the odds of attempting suicide—and was consistent across different informants and victimization types." The authors concluded that victimization was "likely a causal factor in suicidal ideation and self-harm" (p. 512) but that family-wide genetic vulnerabilities (e.g., poor emotion regulation, impulsivity) and unsupportive environments also played a major role.

Among the various forms of maltreatment, PM, in particular, shows very strong links to suicidal behavior and nonsuicidal self-injury (NSSI) in cross-sectional and retrospective studies. A recent meta-analysis of 15 international studies (Liu et al., 2017) found that suicidal behavior and childhood abuse were closely linked in both the total population and in clinical groups, with emotional abuse having the strongest effect among the five subtypes of child maltreatment (it more than doubled the risk). The relationship

between PM and suicidal behavior was strongest in the chronic schizophrenic patients. Seff and Stork (2019) had similar findings, tying emotional abuse in particular to suicidal behavior, controlling for other forms of maltreatment. These authors used the Violence Against Children Surveys administered to nationally representative samples of 13–24-year-olds in three low- and middle-incomes countries: Tanzania, Kenya, and Haiti. In a large epidemiological sample of over 14,000 mainland Chinese adolescents from four major regions of the country, all forms of maltreatment were associated with significantly higher risk of NSSI (2.5 to 4 times higher); however, when all forms of maltreatment were entered simultaneously into the regression equation, physical abuse, emotional abuse, and sexual abuse remained significant (Wan, Chen, Sun, & Tao, 2015). Croyle and Waltz (2007) found only emotional abuse related to NSSIs.

Emotional Problems and Symptoms

Caslini et al. (2016) conducted a systematic review and meta-analysis of child maltreatment and eating disorder studies. They found that child PM and physical abuse were significantly associated with bulimia nervosa and binge eating disorder in the six retrospective studies meeting their criteria for inclusion in the analysis. In regard to PM, the authors speculated it played a causal role in the development of eating disorders because of its high prevalence and its influence on "dissociative coping styles, self-control through self-starvation, and emotion regulation" (p. 86).

Child maltreatment and thinking disorders are strongly linked. As reviewed above, the E-Risk study found that victimization in adolescence was related in a dose-response fashion to a significantly higher incidence of thought disorders as well as internalizing and externalizing problems. Many other studies have found this dose-response relationship between maltreatment and thought disorders. For example, child maltreatment is related to retrospective reports of significantly higher reports of dissociative symptoms in both community samples and samples with psychotic disorders, such as schizophrenia (e.g., Goff, Brotman, Kindlon, Waites, & Amico, 1991; Lange et al., 1999; Mulder, Beautrais, Joyce, & Fergusson, 1998).

A number of studies have found PM significantly more predictive of psychotic symptoms than other forms of maltreatment. For example, Varese et al. (2012) conducted a meta-analysis of patient-control, prospective, and cross-sectional studies on the relationship between "childhood adversities" (which they defined as all five forms of CM, bullying, and parental death) and psychosis. They found an estimated population attributable risk of 33% (16%-47%) with findings similar across all three research designs. All types of adversity were statistically related to an increased risk of psychosis although emotional abuse had the highest odds ratio (3.40) followed by physical abuse (2.95). Using an Australian prebirth cohort (N=3752) that gathered information on CPS-substantiated cases (birth to age 14), Abajobir et al. (2017) found that exposure to any child maltreatment, particularly emotional abuse and neglect, significantly increased the likelihood of self-reported hallucinations, lifetime delusions, and lifetime psychotic events when assessed at age 21 as opposed to those not maltreated. Notably, most maltreated individuals did not report psychotic experiences. In other studies, PM was related to a significantly increased risk for dissociative symptoms in community samples after controlling for other forms of maltreatment (e.g., Mulder et al., 1998; Teicher & Vitaliano, 2011). Similar findings on the strong, significant relationship between childhood PM and dissociative symptoms in adulthood are found in Braehler et al., (2013); Brunner, Parzer, Schuld, and Resch (2000); Lange et al. (1999); Mulder et al. (1998); and Schalinski and Teicher (2015).

Social Competency Problems and Antisocial Functioning

PM's strong relationship with social competency problems is seen in the area of parenting an individual's own children. For example, Bailey, DeOliveira, Wolfe, Evans, and Hartwick (2012) queried a sample of high-risk mothers about their child maltreatment experiences, their parenting competency, and stress followed by structured observations of their parenting. Retrospective reports of witnessing family violence (a form of PM) and other emotional maltreatment in childhood were significantly related to mothers' observed hostility toward their children, even after controlling for other

forms of potentially traumatizing adult experiences. Parenting competence and its relationship to self-reported childhood trauma was examined in a sample of low- and high-risk parents with intellectual disabilities (ID; McGaw, Scully, & Pritchard, 2010). Having a CPS referral and being referred to a specialist parenting group for help was not associated with IQ, relationship status, parental age, or employment. Instead, it was associated with parental reports of childhood trauma (particularly emotional abuse and physical neglect), parents having additional special needs beyond low IQ, and raising a child with a disability.

While PM alone, or in combination with other forms of maltreatment, seems particularly tied to internalizing and thinking problems, emotional abuse combined with physical abuse (a common pairing), is associated with conduct-related problems such as delinquency and sexual risk behaviors (Norman et al., 2012). For example, Berzenski and Yates (2011) demonstrated this relationship with a sample of 2,000+ college students who completed measures of their childhood abuse history (but not neglect), current psychopathology, dating violence perpetration, substance use, and risky sexual behavior. Using Latent Class Analysis, the authors identified patterns of maltreatment experiences. The entire sample consisted of maltreated and nonmaltreated clusters, with the maltreatment cluster having four subgroups mapping onto the four types of child maltreatment. Of those experiencing multiple forms of maltreatment, there were four subgroups: Hostile Home (domestic violence and emotional abuse), Violent Home (domestic violence and physical abuse), Harsh Parenting (physical and emotional abuse), and Sexual Abuse (sexual abuse alone or with any other form of maltreatment). Participants who experienced any form of emotional abuse (with or without other forms of maltreatment) reported significantly higher psychopathology than any group that did not include emotional abuse. Conduct problems occurred most frequently in the Harsh Parenting group, particularly substance abuse, and especially among young men. Prospective studies have also found a strong link between emotional and physical abuse and conduct problems. Emotional abuse in childhood (based on maternal interview at the time) predicted self-reported criminal behavior in a sample of 365 adults from the

Lehigh Longitudinal Study. Physical abuse predicted adult criminality indirectly through childhood antisocial behavior while emotional abuse predicted adult crime directly and indirectly through childhood conduct problems (Jung, Herrenkohl, Lee, Klika, & Skinner, 2015). In a prospective study of LSES high-risk families and community two-parent families, Maughan, Pickles, and Quinton (1995) found that maternal hostility in childhood (based on interview of mother and observer ratings of hostile and rejecting behavior) predicted contemporaneous teacher-rated behavior problems, diagnosed conduct disorders (based on parental interview), and poor adjustment in adulthood (poor social functioning, problems at work, and criminal history). With maternal hostility in the statistical model, parental psychiatric disorder, maternal lack of warmth, marital discord, and paternal hostility were not significant predictors of childhood conduct problems or adult antisocial behavior. Only parental criminality added significantly to the prediction beyond maternal hostility. Fifty percent of children, male and female, with hostile mothers in both the high-risk and the community samples had childhood conduct problems. The best-fitting model suggested that maternal hostility led to the development of conduct problems and, in turn, the presence of conduct problems in childhood predicted poor adult functioning.

Substance abuse and PM have been strongly linked in both retrospective (e.g., Berzenski & Yates, 2011; Norman et al., 2012) and prospective studies such as the Lehigh Longitudinal Study (Jung et al., 2015) and Australian pre-birth cohort described earlier (Abajobir et al., 2017), even when controlling for other forms of maltreatment.

Learning Problems and Behavioral Problems

There is a large cross-sectional and prospective literature showing that emotional and physical neglect are strongly related to cognitive deficits, including lower IQ and neuropsychological deficits. Psychological abuse is either unrelated or shows a weaker relationship to cognitive functioning than other forms of maltreatment; however, it is related to behavioral problems that adversely effect schooling and educational outcomes (see reviews by O'Higgins, Sebba, & Gardner, 2017; Romano, Babchishin,

Marquis, & Frechette, 2014).

One of the most powerful demonstrations of the relationship between emotional neglect and cognitive decline comes from the Minnesota Longitudinal Study of Risk and Adaptation. Egeland, Sroufe, and Erickson (1983) used repeated home and laboratory observational methods and CPS reports from infancy on to identify child maltreatment in a prospective longitudinal study. High-risk mothers (N= 267) were recruited prior to the birth of their first child and the families followed forward in time. At 18 months, children with psychologically unavailable caregivers showed anger, noncompliance, and low-positive affect during problem-solving tasks and a significant decline on the Bayley Scales of Infant Development, with average developmental quotients at 12 months declining to well below average at 18 months. By preschool, children with a psychologically unavailable caregiver or one who was hostile/verbally aggressive had more teacher/caregiver reported psychopathological behavior than other high-risk controls. All of the maltreatment groups were significantly more noncompliant, avoidant, and negative with their caregiver and less persistent and enthusiastic in learning than nonmaltreated control children (Egeland & Erickson, 1987; Pianta, Egeland, & Erickson, 1989).

Another prospective study showing a relationship between emotional neglect and cognitive functioning is a 1958 British birth cohort study (N=8,928) by Geoffroy, Pereira, Li, and Power (2016). Psychological and physical neglect in childhood (ages 7 and 11) significantly predicted (a) low childhood cognitive functioning (math, reading and IQ), (b) poor age 42 educational qualifications, and (c) lower age 50 memory and processing speed scores, controlling for a comprehensive set of covariates including mental health. Psychological abuse was not related to cognitive functioning, and the other forms of abuse (physical, sexual, and witnessing domestic violence) were not related after controlling for other confounding variables. All forms of maltreatment were related to more childhood behavioral problems and adult depressive symptoms, controlling for numerous confounding variables.

Other studies showing a negative effect on learning from neglect, but not emotional abuse, include an Australian population-based cohort study that linked CPS records (e.g., unsubstantiated maltreatment, substantiated maltreatment, out of home placements), disability records, and health records for 46,000+ children (Maclean, Taylor, & O'Donnell, 2016). The predictor variables were maltreatment allegations (emotional, sexual and physical abuse, and neglect), controlling for other risk factors (e.g., maternal smoking, maternal mental health contacts of any type). The dependent variable was low reading achievement on the national third-grade reading test. Emotional abuse was no longer significantly related to poor reading after controlling for other risk factors, but sexual and physical abuse and neglect were related, such as a 50% increased odds of low reading achievement. A separate western Australia linkage study of 19,000+ kindergarten-age children related all previous CPS reports to performance on an extensive school readiness battery (Bell, Bayliss, Glauert, & Ohan, 2018). All forms of substantiated maltreatment were related to lower readiness as were unsubstantiated physical abuse and neglect. Unsubstantiated emotional and sexual abuse were not related to test scores.

A recent study, on the one hand, has not supported a causal relationship between cognitive deficits and maltreatment. Danese et al. (2017) examined two birth cohorts: The E-Risk study born in 1995–1996 and the Dunedin New Zealand birth cohort born in 1972–1973. They confirmed the relationship of victimization (particularly neglect and physical abuse) with pervasive cognitive deficits in IQ in childhood and adulthood and with neuropsychological deficits in adulthood. However, after removing from the analyses children who were maltreated in early childhood, and then controlling for family SES, early childhood intellect/language ability, and maternal IQ (in one study), the relationship between victimization and cognitive deficits was mostly nonsignificant. The authors concluded that cognitive deficits in maltreated children and adults should be viewed as risk factors for victimization and not the result of maltreatment. More work of this quality is needed to resolve this question.

On the other hand, the E-Risk study found strong support for child maltreatment having a possible causal relationship with poor educational qualifications at age 18 and not being in education, training, or work at that age (Jaffe et al., 2018). Maltreated children were twice as likely to have poor educational qualifications (e.g., school leaving certificate). After controlling for sex, family SES, parental psychopathology, and IQ at age 5, the relationship was diminished; however, it was still significant. The authors concluded that the relationship between maltreatment and poor educational outcomes was not due to being raised in a poor neighborhood or of having a low IQ. It was also not due to being more vulnerable to psychopathology because one's parents had mental illness with poor educational or occupational prospects as the result. Instead, their findings were consistent with "maltreatment jeopardizes education and employment prospects by increasing the risk of poor mental health in childhood" (p. 1146). The researchers did not have enough twins discordant for maltreatment to test for the specific effects of each form of maltreatment.

Physical Health Problems/Adverse Biological Changes

Most of the evidence in this category comes from retrospective studies like ACEs because longitudinal studies before the 1970s did not routinely assess for child maltreatment and some major studies did not include PM until the 2000s (e.g., E-Risk). The original ACEs studies statistically tied the retrospective report of all forms of child maltreatment to many of the leading causes of death in adults (e.g., ischemic heart disease, cancer), promiscuity, unintended pregnancy, sexually transmitted diseases, smoking, and early smoking onset as well as psychopathology reviewed above.

An example of a prospective study relating PM to health problems is the 21-year follow-up of a large Australian sample tracked prior to birth into adulthood (N = 2,661, original sample of 7,223). Child abuse and neglect were substantiated for ages from birth to 14, and height was measured in young adulthood. Physical and emotional abuse and neglect were significantly related to a deficit in height after a comprehensive set of perinatal and family confounding factors were controlled, with each additional child maltreatment report related to a 0.03

cm decrease in the height of the young adult (Abajobir, Kisely, Williams, Strathearn, & Najman, 2017). The same authors revealed a relationship between child maltreatment prior to age 14, particularly emotional abuse, and self-report of physician-diagnosed asthma at age 21 (Abajobir et al., 2017).

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Another recent example is from the Japan Environment and Children's Study, "an ongoing nationwide population-based birth-cohort study designed to determine environmental factors during and after pregnancy that affect the development, health, or wellbeing of children" (Komoria et al., 2019, p. 193). Controlling for 16 potentially confounding variables (e.g., noisy environment, smoking during pregnancy) in the 79,985 mother–infant pairs with complete data, the authors found that maternal reported verbal abuse by her partner during pregnancy was significantly associated with a hearing referral for the infant after two failed screening in the first week of life (adjusted odds ratio: 1.44; 95% confidence interval: 1.05–1.98). About 60% of infants failing the initial screening were diagnosed with hearing loss and the remaining 40% with immature auditory development. Physical abuse of mother by partner was not related to hearing referral. The authors proposed multiple causal pathways through which verbal abuse may cause hearing impairment and concluded that "these data suggest that a loud, non-maternal voice experienced in conjunction with maternal tachycardia likely create an environment that is uncomfortable for fetuses and therefore may negatively affect auditory function development in the child during gestation and after birth" (p. 199).

Summary and Conclusion

The studies presented above are not exhaustive. Rather, they are intended to provide a brief overview of the breadth, depth, and international representation of the voluminous research that now exists on the effects of PM, alone or in combination with other forms of child maltreatment, on child and later adult functioning. As the recent publication dates indicate, researchers across the world from different disciplines are now recognizing the lifelong, multi-domain relationship between childhood PM and including it as a variable in a myriad of studies on risk factors for mental, physical, and social maladaptation across the lifespan. This recognition by the research community has been long in coming, but the evidence on the likely harmful effects is now indisputable. Nonetheless, many parents, child welfare personnel, health care professionals, judges, educators, and the general public are still unaware of how harmful PM is and the many ways it is related to impairments in human functioning, especially when the PM is chronic and severe.

About the Author

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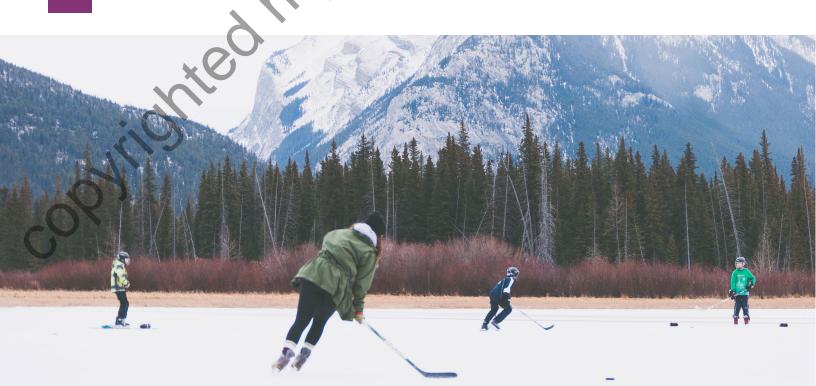# Reported Rates of Psychological Maltreatment and U.S. State Statutes: Implications for Policy

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Implications of Psychological Maltreatment for Universal Intervention

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Key words: Psychological maltreatment, emotional abuse, emotional neglect, child maltreatment, violence against children, well-being, child rights, public health approach, INSPIRE

"One billion children have experienced physical, sexual, or psychological violence in the past year."

This research-based conclusion was reported by INSPIRE (World Health Organization [WHO], 2016), a program of ten international organizations intended to provide guidance to end violence against children worldwide. The likelihood that most of those experiencing physical and sexual violence (i.e., abuse and neglect) were also psychologically maltreated (see Hart & Brassard, 2019, in this *Advisor*) underscores the enormity of the challenge and need to combat this form of maltreatment.

There is increasing agreement that intervention should be given top priority in battling maltreatment of children—that gathering more information about prevalence, incidence, and harm, while of value, should now be considered secondary (see for example, Finkelhor, 2016). Intervention here is used to cover all actions taken to prevent and correct maltreatment, including promotion of child well-being across the life span.

To our knowledge there are no interventions presently in use that were developed specifically to deal with psychological maltreatment (PM; Hart, Brassard, Baker, & Chiel, 2017). That in itself is not necessarily a serious problem, for many available interventions have components that do or can serve to give attention to PM, or can be enhanced to do so. The greater problem

is that traditional child protection interventions, particularly those targeting physical and sexual violence, are after-the-fact reactions, narrowly focused, emphasizing short-term applications to achieve safety. While they give little attention to PM, they are also recognized to be more generally inadequate (Brassard, Hart, Baker, & Chiel, 2019; Chen & Chan, 2016) and to include instances of children being further abused by and within the system, families wrongfully stigmatized, at-risk children poorly monitored, and a disconnect between research, policy, and practice (see Hart, Lee, & Wernham, 2011, p. 972).

Review of this state of affairs has led to the recent establishment of the National Foundation to End Child Abuse and Neglect, which is searching for ways to constructively disrupt traditional goals, strategies, and practices and to reframe child protection in health, mental health, and public health terms. Compatible with this initiative are proposals (see Brassard et al., 2019) that primary prevention, with emphasis on promotion of child well-being, should be given first order priority in intervention, that a child rights-informed public health approach should be applied, and that these themes should be infused harmoniously and synergistically across the three intervention tiers—prevention, risk reduction, and correction. The well-being and child rights components help to emphasize proactive measures that are holistic and integrative; help avoid iatrogenic dangers (i.e., narrowly focused helping that unintentionally damages); serve to frame intervention as invitational, respectful, and engaging rather

than coercively imposed; and are likely to generate necessary sustainable moral/ethical will and raise normative standards.

The public health approach emphasizes attention to fundamental causes and coordinated community-wide primary prevention and promotion of well-being for all children and every child, not just achievement of the absence of pathology, across physical, mental, social, spiritual, and moral domains (Krugman & Wooley, 2018; WHO, 1948; United Nations General Assembly, 1989). (For an overview related to PM, see Hart & Glaser, 2011.) All of these themes and components are likely to be most powerfully and beneficially applied if those managing and implementing the components of the three tiers of intervention take necessary steps to achieve close coordination, mutual respect, and support across the three tiers, freed from the silo-separated territorial interests, policies, and actions of current practice. According to Bart Klika, Chief Research and Policy Officer for Prevent Child Abuse America, coordination and synergy across societal intervention tiers responsible for securing the safety and well-being of children are generally weak to nonexistent. Substantial improvements are needed, and these will require overcoming existing conditions of limited funding, territorial imperatives, limited breadth of capacities, and lack of sufficient support from local norms (personal communication, October 1, 2019).

INSPIRE provides an international framework that is also useful nationally and locally to achieve its vision: "a world where all governments, with the strong participation of civil society and communities, routinely implement and monitor interventions to prevent and respond to violence against all children and adolescents, and help them reach their full potential" (WHO, 2016, p. 4). Here, some of the many promising directions for PM-relevant interventions worthy of consideration are highlighted by placing them in the framework of the "seven strategies for ending violence against children" employed by INSPIRE. Those seven strategies, under which samples of interventions are framed below, have intuitive and research validity, in addition to having been formulated and selected through a rigorous development process advised by a wide range of

experts and 10 expert organizations (WHO, CDC, End Violence Against Children, PAHO, PEPFAR, Together for Girls, UNICEF, UNODC, USAID, World Bank) (WHO, 2016)

INSPIRE includes two quite useful cross-cutting activities to strengthen the application of the seven components of this framework: (1) multisectoral action and coordination (across stakeholder groups and sectors of community enterprise and service) and (2) monitoring and evaluation. The priorities recommended at the beginning of this paragraph can be nicely related to these: the superordinate goal of child well-being is logically a priority for monitoring and evaluation, and the child-rights enlightened public health and three-tier approaches should be at the heart of multisectoral action and coordination.

The reader may have frameworks for organizing the intervention strategies and components considered under INSPIRE's framework that augment the possibilities for their appreciation and application. For example, "Structure" (e.g., laws, regulations, and declarations establishing goals/purposes), "Process" (e.g., resources, capacity building, and processes employed to pursue goals/purposes), and "Outcomes" (status of success in achieving goals/purposes) categories, sometimes referred to as "SPO," are used internationally for framing human rights indicators (Office of the High Commissioner of Human Rights, 2012). They can be applied in any program for advancing the human condition. The primary, secondary, and tertiary prevention categories long used for child protection, reframed as three-tiered intervention in this article and adding promotion of well-being to primary prevention, are clearly suitable for best-fit sorting and for encouraging applications operationalizing INSPIRE's multisectoral and coordination cross-cutting activity. Framing according to social sector or social-ecology relevance would also be helpful. In this article, it is left to the reader to make additional framing choices and applications.

The presentation is heuristic in nature and intended to inspire advances in planning and implementing interventions that will deal with psychological maltreatment more effectively than is presently the case. However, the well-intentioned reader

may be frustrated and possibly overwhelmed by the large context and wide range of options herein recommended for consideration and the accompanying major, probably dramatic, shifts in opinion, purpose, strategy, and support required for their implementation. To constructively, not necessarily comfortably, deal with these realities, it is recommended that selections for further study and implementation should be made that are judged to be doable according to opportunity and capacity, giving priority to selections that have genuine "building block" possibilities for advancing toward stepwise comprehensive intervention.

Implementation and Enforcement of Laws

Laws and regulations specific to PM (i.e., emotional harm, psychological/emotional abuse and neglect, mental injury) are quite diverse and uneven across the United States, varying from nonexistence in six states to approaching full use of the major categories employed in APSAC publications and guidelines (APSAC Taskforce, 2017; Baker & Brassard, in press; Brassard et al., 2019; Hart et al., 2017; Baker, 2019). First priority status should be given to include PM, its definition and forms both in child abuse/protection statutes and in supportive regulations in a consistent fashion across states. This is likely to significantly strengthen opportunities for understanding, appreciation, and application of PM knowledge within states and across the nation. More particularly, employment of the PM definitions and forms found in APSAC resources is encouraged because of their comprehensiveness and support from expert opinion and research.

These standards are consistent with United Nations guidelines (see U.N. Committee on the Rights of the Child, 2011; see Hart, Lee, & Wernham, 2011, for context) and encompass and advance those recommended for national use (Center for Disease Control [CDC], 2008) and those used internationally (see CDC, n.d.). As concluded by Barker and Brassard (2019) from their review of state statutes and reporting practices and findings, "A common, reliable definition of PM (and other forms of maltreatment) in CAPTA, NCANDS, and United States state statutes is necessary for the U.S. to have a surveillance system that allows

for the assessment of the effects of policies on reported rates of all forms of maltreatment" (abstract). It is probable that inclusion of PM in state standards and regulations will progress most effectively if the initial focus is on its clearest, most blatant and destructive occurrences, its association with other forms of maltreatment, and its relevance for interventions before being given more comprehensive attention. The establishment of a coherent framework of laws and supportive regulation has relevance across the three tiers of intervention, establishing community/societal norms for responsible behavior as well as guiding interventions for risk and violence.

Norms and Values

Finkelhor (Hart & Glaser, 2011) has suggested that raising normative standards is one the most promising of maltreatment primary prevention strategies. If PM and other forms of child maltreatment are to be reduced significantly and child well-being is to be promoted and advanced, norms for the valuing, care, health, and development of children must be raised across the full social ecology. The establishment of laws and regulations as considered in the last section will help to promote norms for valuing and protecting children. Related further advances can be made through public media campaigns and community engagement to generate and coalesce around values and expectations. Multiple experts interviewed recently regarding PM (in preparation for the Psychological Maltreatment Summit, October 2019) have suggested the successful public health campaigns of the last few decades should be used as models (e.g., anti-smoking, against drunk driving, for seat-belt use, mammogram promotion, avoidance of processed sugar and hormones in food). For well-being and resiliency, two programs offering a wide range of opportunities for promotion are the "developmental assets" framing of the Search- Institute (Scales, Leffert, & Lerner, 2004; Search-Institute, 2019) and the Student Support Card (Brightways Learning, 2019).

Public media attention for PM generally has been seriously lacking. There are exceptions, including the Menendez case (Rand, 2018) and DaddyOFive (British Broadcasting Corporation [BBC], 2017). These suggest that the presentation of real-life stories, or vignettes of important portions, will draw public attention and

offer opportunities (generally missing from media) to clarify issues, consider values to be promoted, and offer ways to do this practically and responsibly, including achieving supportive community solidarity and accountability for related priorities and interventions.

In this regard, the traction gained by the Adverse Childhood Experiences study (Anda, Butchart, Felitti, & Brown, 2010), which included PM and significant associated findings, has the potential to garner widespread PM-related attention and intervention. This relatively "easy to administer and understand" tool might quite beneficially be expanded to include more refined attention to the different forms of PM and to "advantageous" or "beneficial" childhood experiences with research evidence for advancing resiliency and well-being. Such a tool widely used and connected to interventions to prevent maltreatment and promote well-being could become a rallying point across the social ecology. This program of work is being explored within the Psychological Maltreatment Alliance (APSAC, New York Foundling, School Psychology Program of Columbia University, and International Institute for Child Rights and Development) in cooperation with a panel of international experts on child well-being, with the intention of soliciting guidance from children and youth. Previous constructive efforts in this regard are promising and instructive; for examples see "What's your ACEs score? – What's your resilience score? (Stevens, 2017; Finkelhor, Shattuck, Turner, & Hamby, 2013; Cronholm et al., 2015).

Safe Environments

Safe psycho-social environments can be recognized, understood, framed, promoted, and established in all sectors of the social ecology. Attention should be given to tracking the related experiences of children/youth and soliciting their views regarding the physical and social contexts in which they experience danger and safety (e.g., home, neighborhood, childcare, school, recreation, work, cyberspace) and how these might be managed to strengthen interventions across all tiers (Lansdown & O'Kane, 2014; UNICEF, 2018). For families, safety formulations can be built pro-actively, for example, see the "Non-Violence in the Family" section of *Parenting for Peace and Justice* (McGinnis

& McGinnis, 1982), which contains opportunities for PM inclusion in guidance on establishing an affirming, cooperative family environment; nonviolent communication skills; nonviolent conflict resolution; family meetings; and constructive discipline. When working with recognized risk conditions and maltreatment histories, the "safety-plan" requirements of child protective services programs can be upgraded to give particular attention to both the elimination of psychological maltreatment and the promotion of well-being (Tabachnick & Pollard, 2016; U.S. Department of Health and Human Services [USDHHS], 2019).

The Inclusive Schools Network (2019) states that "a safe and caring school environment is one in which students feel positively connected to others, respected, that their work is meaningful, and that they are good at what they do" (p. 1)—all of which promote human needs fulfillment and thwart PM. The Network lays out a plan for establishing a positive climate through collaborative support and sharing information and responsibility, including developing a code of "civility." This could be used to provide an initial planning guide. The "Just Community" schools model provides guidance toward empowerment of students to take primary responsibility to frame, secure, and manage a healthy and respectful school environment (Power, 1988; ERIC, 2019). Rotary International's (n.d.) "Interact" program promoting "Service above Self" has spawned an anti-bullying campaign in Leesburg, Florida, which guides and commits students to end bullying, take related action, and promote a positive interpersonal environment (see related PledgeAgainstBullying.com).

Similar intentional consideration of PM and the supports for well-being can be given attention in recreation and work environments. The most powerful supports for establishing and maintaining safe environments for children and youth are likely to be found in intentional establishment of cohesive circles of caring and stewardship for children (e.g., parents, teachers, faith community leaders, coaches) (Hart & Hart, in press b) that commit to, track, and support safe environments. This conceptualization is similar to the encouragement by Rich (1998) to establish a "small town" in every context of living, which will

promote well-being and act when deviance or distress endanger. In child care and school, the Danish "class teacher" model (Jensen, Nielsen, & Stenstrup, 1992), deserves serious consideration and application. It provides continuity of connection and a family of caring with a particular teacher and set of students across the full school years, similar to but a greatly expanded and strengthened version of the traditional "home room," which can help assure that the well-being of students is championed by school adult and student advocates who also are close observers and bystanders ready to assist themselves and to alert others to assist when problems arise. For the multiple social environments of children, establishment of intentional and facilitated circles of caring for each child should be given high priority. Advances in evolving technology (e.g., for information gathering, storage, organization, prioritizing, and accessibility) to connect the social support web as well as monitor, alert, and guide assistance will make this increasingly feasible (see for example the development of apps for parents, Singer, 2019).

Parent and Caregiver Support

Valuing, empowering, and supporting parenting will increase the likelihood of positive parenting, which includes avoidance of PM and provision of psycho-social caring and respect. Programs provided in the home, community, schools, and online should advance understanding and appreciating psychological needs, recognizing their expressions in the infant/child/youth, and responding positively and meaningfully. Useful guidance regarding programs is available (Collins & Fetsch, 2012; Samuelson, 2010). In terms of essential capacity and behavioral components to incorporate in parent preparation, the following have been recommended, all of which to greater or lesser degrees will counter PM and promote well-being: knowledge of child development, skills to enable sensitive responses to infant cues and knowledge of why it's important to do so, social support, coping strategies, active reflection, empathy and compassion, permission for and guidance in setting appropriate boundaries, and mutually respectful conflict resolution (Brassard et al., 2019).

The home visitor model provides a parent and caregiver support model relevant at all tiers—for first-time mothers, those in risk conditions, and those where maltreatment has occurred. If it adequately incorporates attention to PM dangers and promotion of positive psychological care, it provides good reason for optimism about preparation and support for good parenting; and it has been argued effectively that it should be made available to all caregivers (Brassard et al., 2019; Davis, 2014). The promising outcomes from the "Strong Communities" programs provide rationale for using its components to promote multiple sector community support to reduce child maltreatment and promote child safety (McDonell, Ben-Arieh, & Melton, 2015). All-community and all-state programs, based on youth development research, including consideration for the Search-Institute's developmental assets framework, have been created to promote parent and parent surrogate (e.g., adults in schools, faith communities, recreation/sports, community service agencies) support for child health, development, and well-being (see Peterson, 1998, 2012, 2014, 2018). They have the potential for strong cross-sector and multiple-tier success and deserve strong consideration in intervention planning.

Income and Economic Strengthening

INSPIRE's establishment of the category of income and economic strengthening encourages us to identify, construct and generate conditions likely to prevent or end violence against children related to influences of material poverty and economic stress. This recognizes the reality that lack of sufficient economic sources can debilitate, depress, degrade, and create despair—all psychological states increasing the likelihood of ill-conceived interpersonal actions destructive to others and self. Such conditions are recognized as identified risk factors for communities, parents and families (Brassard et al., 2019), and there is some evidence that child well-being is advanced by financial support for families in economic stress (Sherman, Trissi, & Parrot, 2013). Interventions can be applied to overcome or assure protection from lack of sufficient resources and to assure adequate support for basic needs of shelter, food, clothing, health services, and transportation. INSPIRE's intervention list includes the following: cash transfers, group saving and loans combined with gender equity training, and microfinance combined with gender norm training. The application of these

measures as recommended would be accompanied by commitments to actions by caregivers that will benefit children and family members (e.g., to send children to school and provide education to respect women and reduce domestic violence).

Most of INSPIRE's expected outcomes from income and economic strengthening are highly relevant to combatting PM: e.g., reductions in physical violence toward children by parents or other caregivers; reductions in intimate partner violence; reductions in early and forced marriage of young girls; reductions in children witnessing intimate partner violence in the home; and increases in social norms and attitudes that disapprove of intimate partner violence. These conditions are relevant across the world and cultures, albeit in somewhat different expressions. Guaranteed basic income and negative income tax programs have been recommended and are being piloted in many parts of the world, including the United States, to prevent and counteract the human quality of life danger of economic distress (see Lowrey, 2018; McFarland, 2017; Winick, 2018).

A research-based case has been made for the likelihood of child maltreatment leading to impoverished adult life (Bunting, 2018). Similarly, economic stress and poverty have been found to increase the likelihood of children being maltreated, particularly if accompanied by adult psychological conditions of depression and social isolation (USDHHS, n.d.). This state of affairs, likely to be exacerbated by the elimination of jobs through technological advances, strongly argues for considering initiatives such as universal basic income support, in ways that provide opportunities for achieving and maintaining a sense of personal integrity through meaningful work, contributions to family and community well-being, and management of resources. While there are no simple answers here, it certainly makes sense to help parents and those who will be parents, from early on, explore and develop their talents, critical thinking, values, character, pro-social behavior, and ability to establish social support networks. This can be done in ways that serve them in finding constructive and appreciated outlets for their capacities and interests, make good choices, manage their resources, including income, and treat others and

be treated by others, including family members, well, particularly under duress. Guidance in this regard is available (Goleman, 2006a; Goleman, 2006b; Tough, 2012).

Response and Support Services

The likelihood of meaningful response to conditions of high risk for or existing PM will be greatly increased if potential responders are equipped with frameworks of PM forms, mediators, and outcomes in order to monitor needs and apply an array of proven or promising interventions, including support services. This is true for responders who have no official related responsibility other than being ethical, caring individuals observing families from within or through other relationships in which maltreatment might occur, in addition to those with official responsibilities in child and family services. Therefore, PM, its nature, forms, outcomes, and related interventions should be included within all public information and education programs regarding conditions dangerous to children's health, development, and well-being as well as within every surveillance, data gathering, investigation, decision-making, and treatment component of child protective services.

In regard to the nature of therapeutic response, expert opinion strongly supports relational therapies that concentrate particularly on the interactions between adult caregiver and child, that strengthen reflective processes by the caregiver, and that promote respectful, responsive, and supportive behaviors appreciating the motivations and needs of both parties (e.g., therapist and client, parent and child; see Toth, Gravener-Davis, Guild, & Cicchetti, 2013). Relational interventions tend to incorporate most of the following components, each of which deserves serious consideration in response and supportive services:

> a home visitor approach; working with parents during the early years of their children's lives; multiple observations and consultation for play, conflict, and other interactions across months; focus on the caregiver–child dyad with priority given to the relational nature of their behavior and interactions; exploration and guidance regarding the child's views/ needs and the caregiver's views/needs as

communicated in behaviors and interactions; guidance in understanding and reformulating representations of self, child, and caregiving; modeling and direct support for improving the parent–child relationship in its natural context. (Brassard et al., 2019, p. 51)

The analysis of the nature and effectiveness of relational interventions provided by Toth and colleagues (2013) has been appreciated and expanded in Brassard et al. (2019), with central results placed in table form.

Among the 12 programs with the strongest supportive evidence are the following: Attachment and Biobehavioral Catch-Up (ABC; Bernard et al., 2012), child–parent psychotherapy (CPP; Pickreign Stronach, Toth, Rogosch, & Cicchetti, 2013), interpersonal psychotherapy (IPT; Weissman, Markowitz, & Klerman, 2000), and multisystemic therapy on child abuse and neglect (Swenson, Schaeffer, Henggeler, Faldowski, & Mayhew, 2010). Steps Toward Effectiveness in Enjoyable Parenting (STEEP; Suess, Erickson, Egeland, Scheuerer-Englisch, & Hartman, 2017) and Program in Relational Interventions (PRI; Moss et al., 2011) are both recognized as worthy of consideration and employ video feedback promoting reflective caregiving. Interventions applicable in and across Tiers 1–3 are included. Brassard and colleagues (2019) provide more coverage and references (see particularly pp. 51–56).

Education and Life Skills

Promotion of social-emotional skills development (WHO, 2016; Goleman, 2006a; Goleman, 2006b) is essential and high on the list of imperatives for pro-active intervention toward reducing PM and achieving well-being. Certainly, social-emotional competency can be facilitated by supportive observations, modeling, encouragement, and intentional instruction in the home (McGinnis & McGinnis, 1982) and in the school (Collaborative for Academic, Social, and Emotional Learning, 2015; Goldstein, 1988); and social-emotional health can be monitored at group and individual levels to guide multi-tier intervention (Furlong, You, Renshaw, Smith, & O'Malley, 2014). Even less than fully authentic pursuit of Gottman's "magic ratio" (i.e., five positive for

every one negative response) for achieving "positive sentiment" override in marriages (Benson, 2017) applied in all interpersonal contexts might leave little room for PM and be so positively rewarded as to become a way of life. The Search-Institute has produced a "developmental relationships" framework and guidance toward achieving strong positive and supportive relationships, which deserves application consideration across all tiers of intervention (Roehlkepartain et al., 2017).

Finally, attention must be given to empathy, a foundational and generative component for sensitive, responsive, caring behaviors with, and particular emphasis on, "compassionate" empathy compared with "emotional" and "cognitive" empathy (Goleman, 2007; also see comments on "empathic concern," chapter 6, Goleman, 2006b). This most crucial of human characteristics can be promoted in early life, as recommended by Perry and Szalvatiz (2011), through the "Roots of Empathy" (ROE) program for schools (Gordon & Siegel, 2012), which gives children opportunities to observe infants and develop an understanding of their needs for sensitive and contingent care. Beyond the early years, effective empathy training, which is relevant for all three tiers of intervention, is available (Teding van Berkhout & Malouff, 2016). Recent evidence that "empathic concern" is decreasing in the young adult population provides additional rationale for prioritizing intervention in its regard (Konrath, O'Brien, & Hsing, 2011).

Concluding Remarks—Toward a Better Future

If advances are to be made in psychological maltreatment intervention, both hindrances and opportunities must be addressed. PM is relatively poorly understood and appreciated by the general public and by relevant governmental and professional service sectors, and it is given little attention in maltreatment prevention, risk reduction, and therapeutic interventions. A myriad of intervention strategy and practice options exists, the set described in this article is not exhaustive but worthy of consideration. The INSPIRE structure of strategic themes is useful for organizing intervention elements and for encouraging advances toward sufficiency, coordination, and accountability. This set of conditions

and opportunities raises many critical questions, including where to start in making "building block" improvements that establish fertile ground for additions and what priorities should be set for the major components necessary to frame and support deeper and broader long-term advances in PM intervention.

As to promising beginnings, here respecting the three-tier approach, (1) persons or organizations having influence in the spheres of well-being and primary prevention could justifiably give priority to changing social norms through public education and community action and to achieving secure attachment for all infants (often cited in our interviews with experts as a best single step if only one could be chosen); (2) those involved in risk-reduction could work to be sure PM definitions and PM harm (see Hart & Brassard, 2019, and Brassard, 2019, in this *Advisor*) are included in public information/education and that their proscription is clearly established in social norms, possibly through community adoption of monitoring and support systems applying an "adverse and advantageous childhood experiences" scale; and (3) corrective violence/trauma response service sectors could insure that the most serious forms of PM (e.g., psychological/emotional neglect in infancy) are included in their directives and practices and that all reported child maltreatment is evaluated to determine the associated or embedded PM factors deserving incorporation in therapeutic interventions.

These and other promising strategies are likely to be strengthened individually and in their interactions, short and long term, through progressive establishment of the following widely endorsed supportive conditions (all falling within or across the INSPIRE thematic categories).

- Comprehensive, engaging programs of public information and education to achieve informed support and serious intent for securing the safety (from PM) and well-being of all children,
- Social norm changes that establish supported imperatives and expectations for respectful, caring interpersonal behavior and relations (antithetical to PM),

- Preparation and support to foster reflective, empathic, and respectful relational behavior in child caregiving,
- Inclusion of psychological maltreatment definitions and standards in state, national, and international law and regulation,
- Coordinated and synergistic multi-tiered interventions that promote resiliency and well-being while preventing maltreatment, reducing risks for maltreatment, and correcting existing maltreatment and its harm,
- Systems of monitoring each child's development progress that assure attention to needs,
- Child rights and psychological maltreatment training and education of all child and family serving professions,
- A human rights-informed public health approach that incorporates the foregoing.

The human rights emphasis in the last recommended supportive condition justifies closing mention of a component, child participation and agency, that is given little attention in INSPIRE and generally neglected in child protection. The need to include the perspectives and involvement of children in securing their safety and well-being individually, collectively and in partnerships with adults (in no way suggesting they are responsible for being maltreated), is set forth in the Convention on the Rights of the Child (United Nations General Assembly, 1989). Interested readers will appreciate being alerted to the fact that this theme is being championed in a special issue of the *International Journal of Child Abuse & Neglect* (expected in early 2020) on the child protection relevance of the Convention in articles by Gerison Lansdown and by Anita Kosher and Asher Ben-Arieh. Child participation and agency, arguably, deserve cross-cutting incorporation for child safety and well-being interventions. Lansdown has done extensive research and development work on child participation (Lansdown & O'Kane, 2014; UNICEF, 2018).

Bringing a promising configuration of supports to reality for PM intervention is a huge challenge. The Psychological Maltreatment Alliance (presently including APSAC, New York Foundling, the School Psychology Program of Columbia University, and

the International Institute for Child Rights and Development) is working toward such purposes. It held a global summit of experts on psychological maltreatment at the end of October 2019 to inform its work and widen the cooperating base of expert persons and organizations, the results of which will be made available for consideration by all interested parties. Your perspectives and guidance for the way forward are invited by the Alliance and the authors of this *Advisor* edition.

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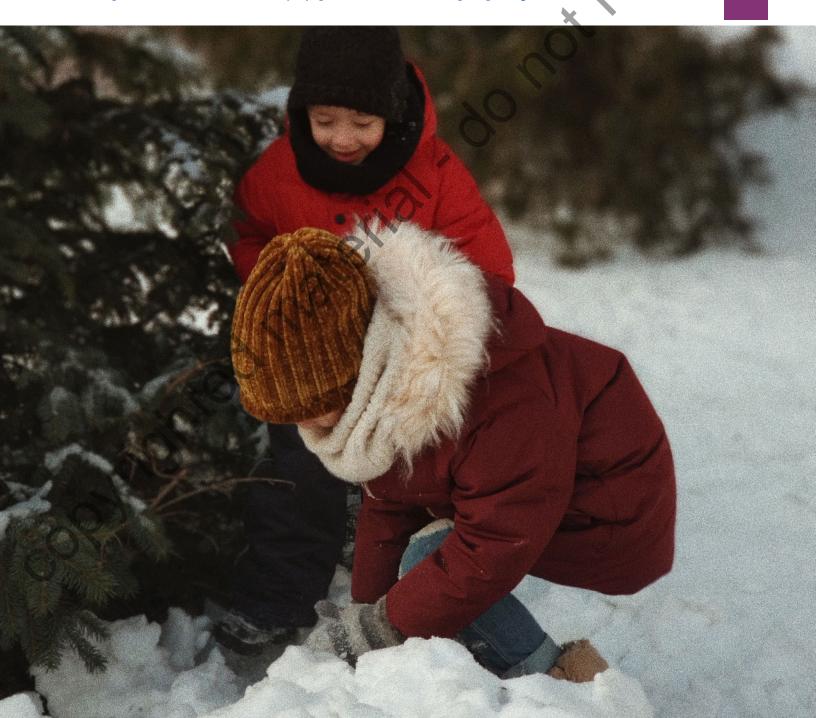
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Widening the Reach of Clinical Interventions to Reduce Psychological Maltreatment

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Key words: psychological maltreatment, integrated behavioral health, child protection, school psychology, child well-being

Psychological maltreatment (PM) is a significant and insidious form of child maltreatment with long-lasting effects. Whereas the effects of physical forms of maltreatment may be immediately visible, psychological maltreatment affects the internal world and well-being of child victims, contributing to a persistent pattern of negative parent–child interactions. *Psychological maltreatment* is defined as "a repeated pattern or extreme incident(s) of caretaker behavior that thwart the child's basic psychological needs (e.g., safety, socialization, emotional and social support, cognitive stimulation, respect) and convey a child is worthless, defective, damaged goods, unloved, unwanted, endangered, primarily useful in meeting another's needs, and/or expendable" (Hart, Brassard, Baker, & Chiel, 2017, pp. 147). A thorough review of the American Professional Society on the Abuse of Children's (APSAC) definition of psychological maltreatment, including clear delineation of psychologically maltreating caregiver behaviors, assessment considerations, risk factors, and interventions, can be found at Brassard, Hart, Baker, and Chiel (2019).

Whereas families may become involved with child welfare agencies only after the concerns with caregiver behaviors rise to the level of being identified and reported to state agencies (for example, a persistent pattern of physical threats and abuse may only be reported after a child comes to school with visible bruises), APSAC's *Practice Guidelines* titled "The Investigation and Determination of Suspected Psychological Maltreatment" (APSAC Taskforce, 2017) advocate for a public health approach to preventing PM and delivering early psychosocial interventions to families at risk. A three-tiered systems approach can more effectively address prevention and treatment of PM (Fiorvanti & Brassard, 2014). In three-tiered models, tier 1 focuses on universal practices to promote well-being and prevention of maltreatment, tier 2 aims to deliver targeted interventions to people identified to be at risk, and tier 3 provides intensive interventions as needed to populations for whom the first two tiers are insufficient.

In support of a three-tiered model of intervention, the present article focuses on methods for widening access to evidence-based clinical interventions. We seek to promote practices for clinicians to provide preventative care to families long before the severity of maltreatment rises to the level of involvement by child protective services. Integrated care models, specifically school-based and pediatric primary care settings, provide mechanisms for increasing access to evidence-based interventions in settings that are familiar and comfortable to families and can provide interventions in a three-tiered approach, addressing a range of needs.

Accessibility of Care

Multiple systemic barriers can interfere with families' access to mental and behavioral health care.

Barriers to intervention may include the following: cultural stigma around seeking help; uncertainty regarding which child-rearing issues may benefit from professional guidance, such as developmentally appropriate expectations and discipline strategies; and structural barriers, such as long waitlists, inadequate insurance coverage, transportation, or childcare concerns (O'Brien, Harvey, Howse, Reardon, & Creswell, 2016; Owens et al., 2002).

Integrated behavioral health and mental health allow for early identification and early intervention/prevention by meeting families in settings where they are already established and comfortable. Statistics indicate that 79%–90% of young children in the United States attend well-child visits with a pediatrician, making it one of the best places to universally access and support families of children at all ages (U.S. Department of Health and Human Services, 2014; Child Trends Databank, 2018). Furthermore, as children above age 5 spend the majority of their time in school settings, school-based mental health programs provide advantageous opportunities to integrate mental and behavioral health treatment into a familiar setting that many families trust for more effective, comprehensive, and lasting outcomes (Rones & Hoagwood, 2000). Both school-based and pediatric settings provide opportunities for individuals to access care at a range of intensity levels, as will be discussed further in the context of the recommended three-tiered models. A combined, lifespan approach of supporting families of children birth through adulthood in the pediatric setting, with the addition of school-based mental health once children enter school, is optimal.

Risk Factors as Targets for Prevention and Intervention

Psychological maltreatment can be understood by way of four categories of individual or psychosocial factors that may increase risk of caregiver perpetuation of psychologically maltreating behaviors: community, family, caregiver, and child factors (e.g., Bronfenbrenner, 1979, Cicchetti & Toth, 2016). Community factors may include inadequacy of systematic support, limited support for childcare, high levels of violence and criminal activity, and poverty. Family factors may include high familial

stress, low income, and inadequate social support or connection to community resources, such as schools, religious centers, or recreation. On an individual level, caregivers with psychiatric disorders, unrealistic expectations for their children, and lack of knowledge of appropriate parenting skills, difficulty attending to children's strengths, high stress, and low social support may be at higher risk for engaging in PM behaviors. Finally, although children are never responsible for maltreatment that they experience, certain factors may make them more vulnerable to harm, such as difficult temperament or a mismatch of temperament relative to their caregiver, disruptive behaviors, disability, and developmental level (see Brassard et al., 2019).

With increased awareness of risk factors at various levels, integrated interventions can be designed to more effectively target specific communities and families. For example, from a public health perspective, communities and neighborhoods with multiple community-level risk factors, such as high rates of violence and poverty, should be identified as desirable hosts for integrated and preventative clinical care initiatives.

Furthermore, caregiver and family risk factors can be addressed at a universal level. For example, community workshops or parenting groups in highly frequented settings can offer support to caregivers by offering psychoeducation regarding developmentally appropriate expectations for children, can increase knowledge of positive parenting and effective discipline approaches, and can provide opportunities for increased social support in parenting contexts. Finally, with awareness of risk factors related to individual children, care providers may be better able to guide caregivers towards effective approaches to parenting, while also equipping children with skills that may serve as protective factors. In consideration of factors that increase risk for PM, a discussion of evidence-based practices that address these vulnerabilities in clinical contexts follows.

Evidence-Based Practices in Integrated Settings

Pediatric Primary Care

Integrated behavioral health programs in primary

care are in a prime position to deliver preventive and proactive mental health services to families in a convenient, family-friendly setting. Pediatric offices are universally accessed on a consistent and frequent basis from birth through the adolescent years, meaning these settings are in a unique position to identify need within the general population and offer targeted interventions. In many cases, pediatricians form long-term, trusting relationships with the families they serve. Contrary to the negative stigma that is often associated with mental health care, pediatric care has a positive stigma that can be leveraged to focus on child and family well-being. HealthySteps is an example of an integrated behavioral health intervention using a tiered approach to support families at risk for psychological maltreatment and other forms of abuse (Briggs, 2016). HealthySteps focuses on the role of prevention and early intervention by working with families of young children 0–5 years old. Designed as a dyadic intervention, HealthySteps directly works to build strong parent–child relationships, making it ideal for targeting and addressing potential PM.

The first tier of HealthySteps involves universal screening for all pediatric patients during well-child visits on a variety of child and family measures. Screening measures may explore parental depression, parent and child trauma exposure (for one example of a trauma screening used in primary care, see the Adverse Childhood Experiences (ACEs) Questionnaire, Felitti et al., 1998), social determinants of health, child development, and child social-emotional functioning and well-being. Universal screening allows the HealthySteps specialist to focus more comprehensive interventions on families at higher risk for behavioral health issues and utilize limited clinicians to make the largest impact. A study conducted at Montefiore Medical Group in the Bronx, New York, found that mothers with a history of childhood abuse were more likely to have children with social-emotional concerns on a screening at 36 months when no intervention was provided. However, when HealthySteps was provided during the first three years of life, a comparison group of similar families with mothers with a history of childhood abuse was found to have sub-threshold social-emotional screening ratings at 36 months (Briggs

et al., 2014). More broadly, research on childhood exposure to trauma, negative events, and toxic stress underscores the potential long-term impact on physical health and social-emotional well-being (e.g., Felitti et al., 1998; Horwitz, Widom, McLaughlin, & White, 2001; Thomas, Hypponen, & Power, 2008). Universal screening for family, caregiver, and child risk factors for PM in primary care can help address the intergenerational transmission of trauma.

The first tier can also involve transforming the pediatric clinic through universal education for all staff members. By bringing awareness to the impact of parent and child trauma exposure (e.g., ACEs) and stress on family functioning and by having a mental health professional available for consultation and "warm hand off," all staff members are exposed to, and become part of, the promotion of well-being. For example,

> having blood drawn is a difficult but often necessary part of pediatric well-child visits. A parent's own negative experience or fear of needles may make it difficult for them to be emotionally available to their child and may even result in psychological maltreatment (such as, a parent laughing while a child's blood is drawn; criticizing a child's appropriate reaction by saying, "Boys don't cry," or "No crybabies"; a parent walking out of the room leaving child alone with a grandparent for the procedure). HealthySteps specialists can model for nurses how to gently nurture and coach a parent to emotionally support a child during scary or painful procedures, which in turn allows many more children to have a positive experience at the doctor, a positive parent–child interaction, and a parent to model how to support the child through a stressful experience.

The second tier in HealthySteps involves brief, targeted interventions offered to parents and families in the pediatric clinic with an identified question or concern, often through a warm hand off on the same day that the problem is identified. HealthySteps specialists use a variety of interventions and strategies informed by a range of evidence-based approaches and one's own

areas of expertise, including (in this provider's case) functional behavior assessment (FBA), early childhood mental health consultation (ECMHC; Georgetown University Center for Early Childhood Mental Health, n.d.), motivational interviewing (MI; Miller & Rollnick, 2013), Parent–Child Interaction Therapy (PCIT; Eyberg & Funderburk, 2011), Circle of Security (COS) Parenting (Powell, Cooper, Hoffman, & Marvin, 2014), and Child–Parent Psychotherapy (CPP; Lieberman & Van Horn, 2008). Through consultation and short-term treatment (1–8 sessions typically), the HealthySteps specialist addresses a mild to moderate concern to potentially prevent it from becoming a more serious concern when possible. With regards to psychological maltreatment, these timely, brief interventions have significant impact by interrupting the development of negative parent–child interaction before it becomes a persistent pattern. For example,

> a common clinical situation involves parents of young toddlers who report that their child "does not listen" and that the only way to get them to follow a direction is to say, "Bye, I am leaving without you." While parents can see that this strategy is effective, they often do not consider *why* it is effective, which is related to their young child fearing separation from the caregiver. A non-judgemental conversation about the child's developmentally appropriate fears, validation of the parent's frustration when the child does not listen, and a discussion about ways to give effective commands to toddlers (without threatening separation) are often enough to impact the quality of parent–child interaction and reduce PM. This intervention involves well-timed and thoughtful developmental guidance and psychoeducation, an approach utilized in Child–Parent Psychotherapy (CPP).

The third tier of HealthySteps involves a long-term intervention offered to parents and families identified to have more risk factors that increase the likelihood for the child to develop social-emotional and mental health concerns. This more comprehensive intervention involves the HealthySteps specialist joining with the pediatrician for integrated well-child visits, which assess social-emotional well-being

along with medical health. Importantly, the long-term intervention is offered before any problems are identified in the child, as a proactive and preventive model, and often begins as early as the 2-month-old well-child visit, offering the opportunity to support a positive parent–child relationship from the very beginning. The HealthySteps comprehensive model addresses and targets community, family, caregiver, and child risk factors for psychological maltreatment through a range of interventions (see references for specific interventions above within tier 2) delivered through the important relationship between the caregiver and the HealthySteps specialist. Assessment and support are provided for parental mental health and a parent's own history of trauma and experience of caregiving, for example, by drawing more deeply from the approaches of child–parent psychotherapy and Circle of Security parenting. Anticipatory guidance and normalization are provided about expected, sometimes challenging, aspects of early childhood development, such as temperament, tantrums, stranger anxiety, and limit testing, as well as the ways in which one's history may impact parenting behaviors and how to notice or address those tendencies. In addition to reflection upon one's own upbringing and parenting goals, psychoeducation, modeling, and live coaching are offered to support parents in the development of effective positive parenting skills. Perhaps more important than any specific intervention, the long-term nature of the intervention allows for the development of a trusting, supportive relationship between the parent and HealthySteps provider, in which parents can openly explore the type of parents they want to be and the relationship they want to have with their child.

School-Based Mental Health

School-based mental health programs are uniquely situated to provide multiple tiers of supports and interventions, capitalizing on the benefits of an integrated model through a child- and family-centered approach. A three-tiered model can optimize the capacity of effective prevention and early intervention efforts, particularly in communities where financial and human resources may be limited relative to the level of community needs. A grant-funded school-based mental health program in an urban setting with high rates of chronic stress, trauma, poverty, and

community violence seeks to address this growing need by implementing a three-tiered model.

The first tier focuses on a universal prevention curriculum, described in *Cam's Classroom: A Trauma-Informed Positive Classroom Behavior Management and Emotion Regulation Manual for Elementary School Classrooms* (Kleinman, Kerner, & Chiel, 2018; other examples of school-based universal interventions include Dorado, Martinez, McArthur, & Leibovitz, 2016; Jaycox, Langley, & Hoover, 2018; Pincus & Friedman, 2004). Cam's Classroom is focused on trauma-informed teacher training in classroom behavior management, with an additional component of teaching early elementary students cognitive behavior therapy (CBT)-informed emotion regulation skills. Through this universal prevention program, students learn skills in emotion identification, and cognitive and behavioral coping skills, while also building a relationship with Cam the chameleon, a stuffed animal that students care for and, through symbolic representation in play, use to practice their emotional expression, prosocial caretaking, and coping skills. Teachers are trained in universal trauma-informed practices so that they may interact with students with increased emotional responsivity, while coaching their students to implement behavior and emotion regulation skills. In the context of PM, this preventative program aims to strengthen children's protective factors and build resilience, including prosocial skills, connection to school (Brackett, Reyes, Rivers, Elbertson, & Salovey, 2011; Stewart, Sun, Patterson, Lemerle, & Hardie, 2004), formation of a positive interpersonal relationships with an adult figure (Flores, Cicchetti, & Rogosch, 2005), ability to problem solve and self-regulate emotions (Buckner, Mezzacappa, & Beardslee, 2003), and increase home–school connection (Barnard, 2004).

A common example of the universal program's positive and immediate outcomes, reported anecdotally by teachers, focuses on students who may have historically demonstrated oppositionality or low frustration tolerance when faced with difficult academic tasks. Teachers boast about successful coaching of students to identify their automatic thoughts, often related to low self-esteem (e.g., "I'll never get this"), determine whether it is a "helpful or unhelpful thought," and subsequently call upon Cam's Thinking Machine to turn an unhelpful thought into a helpful thought (e.g., "I can try my best") that will encourage them through the challenging task. In the context of PM, children may internalize messages that cause them to question their self-worth or sense of competence; as such, there are immediate observed benefits of the opportunities for teachers to provide coaching in CBT-informed cognitive coping techniques in the classroom. Notably, cognitive coping techniques are key components of many evidence-based psychotherapeutic practices (e.g., Trauma-Focused Cognitive Behavior Therapy: Cohen, Mannarino, & Deblinger, 2006; Coping Cat: Kendall, 1994) – Cam's Classroom increases access to effective therapeutic practices by providing the intervention to all students at the universal level.

Teachers also are equipped to help understand students' emotional experiences that they may carry from home into the classroom. For example, in lessons focused on increasing emotional awareness, students may share with their teachers that they feel sad or nervous when yelled at by their parents. Though we do not expect teachers to serve as therapists, teachers are in a unique position to help students cope with their emotions throughout the school day. They can also identify families who may need a referral for services; often these are families who would not have been identified without the teachers' training in universal trauma-informed emotion regulation practices. Furthermore, trauma-informed teaching includes educating teachers about trauma triggers and how students' fight or flight stress response may activate in the classroom, aiming to improve teachers' understanding and conceptualization student behavior within the context of trauma rather than intrinsic qualities.

The first tier also includes bilingual (English and Spanish) family engagement events, focused on disseminating skills from the universal prevention program, as well as psychoeducation workshops for caregivers, focused on topics such as positive parenting and discipline practices (Kazdin, 1997; Webster-Stratton & Reid, 2003), developmental expectations, and signs and symptoms of common mental health disorders. By providing community-wide

psychoeducational workshops, equipping teachers and children with trauma-informed behavior management and emotion regulation skills and providing resources to caregivers in high-risk communities, the program aims to ameliorate the risk and effects of PM at a preventative level, while identifying individuals with a greater need for more intensive intervention.

The second tier focused on prevention for families at risk. Elementary school caregivers are invited to participate in evidence-based parent management groups. Though participants are often self-selected, continuity between the universal prevention program at tier 1 allows schools to offer an option to caregivers seeking additional support. Participation in parenting groups, such as Incredible Years (Webster-Stratton & Reid, 2003) and parent management training (PMT) (Kazdin, 1997) have been shown to improve caregivers sense of social support (Marcynyszyn, Maher, & Corwin, 2011), awareness of developmental expectations (Kazdin, 1997), increased positive parenting practices and decreased harsh parenting behaviors (Webster-Stratton, Reid, & Hammond, 2004). A case example illuminates the power of the Incredible Years parenting groups offered in the school-based context:

> A single mother, whose child received Cam's Classroom universal prevention program, regularly attended weekly parenting groups, focused on topics of positive parenting and discipline strategies. Several weeks into the group, the mother disclosed her prior misconceptions about parenting practices, including providing harsh attention for inappropriate behavior and using a belt to threaten and physically punish her child. She relayed her experiences implementing skills she learned in the parenting group, including positive parenting and discipline practices at home, and shared her astonishment—and immense gratitude—that the newly learned strategies were effective. In school, her child presented as socially and academically average student, and therefore would not have been identified solely by observation as in need of additional intervention.

By providing groups focused on evidence-based parenting practices in school, a familiar and comfortable setting, families receive access to information and training that they may not otherwise access. The first and second tier of prevention and intervention delivered in a school-based mental health clinic allows for delivery of evidence-based interventions to a broader population.

Finally, the third tier of intervention in the school-based mental health program provides individualized interventions for children with a psychiatric diagnosis. Many children referred for third tier intensive psychotherapeutic treatment have either previously experienced PM or may be at increased risk for experiencing PM due to increased vulnerability associated with their psychiatric condition (Turner, Vanderminden, Finkelhor, Hamby, & Shattuck, 2011). Clinicians commonly offer trauma focused–CBT (Cohen et al., 2006), alternatives for families–CBT (Kolko, Iselin, & Gully, 2011), Parent–Child Interaction Therapy (Eyberg, Funderburk, Hembree-Kigin, McNeil, Querido, & Hood, 2001), Coping Cat (Kendall, 1994), and other evidence-based treatment approaches. Treatment plans include collateral parent or family components, which focus on strengthening relationships and empowering families by developing parenting skills that best support their children's needs and mitigate the likelihood of increased harm. For example, for a hyperactive child who has difficulty regulating behavior, caregivers will learn effective behavior management techniques and learn to replace harsh verbal reprimands that do not change behavior in the long term, can strain the caregiver-child relationship, and harm the child's self-esteem. Home-based crisis intervention and medication management services are also available when indicated. By offering psychotherapeutic interventions in school settings, there is increased collaboration between clinician, family, and school staff. Particularly for children in classrooms that received the universal prevention program, individual and family therapy are enhanced through individualized reinforcement and application of classroom skills. For example,

> a child who had received Cam's Classroom in first grade was referred for tier 3 interventions in second grade. With a history of chronic

stressors, including housing instability, inconsistent involvement from his father, and witnessing domestic violence, his mother presented as resilient although easily frustrated by her unrealistic expectations of her son. The child began individualized treatment at tier 3 for generalized anxiety disorder. Advantageously, his prior knowledge of basic emotion regulation and coping skills from his previous involvement in Cam's Classroom could be activated, and his ongoing participation in the program allowed teachers to have foundational knowledge for ease of collaboration with the clinician to help manage the child's anxiety in the classroom. Moreover, the collaborative approach encouraged the child's mother to feel empowered to effectively become a part of her child's treatment team, by learning to change her own expectations, cognitive attributions, and behaviors to best support her child. Whereas at the start of treatment, the mother mocked her child for his avoidant behavior and blamed him for being "lazy" and "stubborn," she gained greater understanding of the underlying anxiety driving his reactions. Additionally, as a single parent with another younger child, the mother often relied on her 8-year-old son as a co-parent and partner, confiding in him with her concerns about the family's financial challenges and relying on him for advice in an inappropriate manner for a child his age. With treatment targeting mother's negative attributions, as well as developmentally appropriate expectations and parent–child interactions, the clinician observed reductions in the mother's negative language regarding her child's behavior and his symptomatology, which previously had unintended negative consequences for the child.

Conclusion

Mental and behavioral health services offered in integrated care settings, such as pediatric primary care and schools, provide increased opportunities for families at risk to access high-quality interventions. As recommendations for prevention and intervention of PM move toward a three-tiered public health approach (Brassard et al., 2019), models of three-tiered, evidence-based clinical care in accessible settings—particularly in high-risk communities—should be promoted. Through establishing clear, specific protocols for identifying families at risk in familiar settings, clinicians will be able to extend their reach, providing preventative care when risk of PM is identified. Three-tiered models in integrated settings increase access to preventative tools and provide interventions at a range of intensity levels to more effectively and efficiently reduce the risk and adverse consequences of PM.

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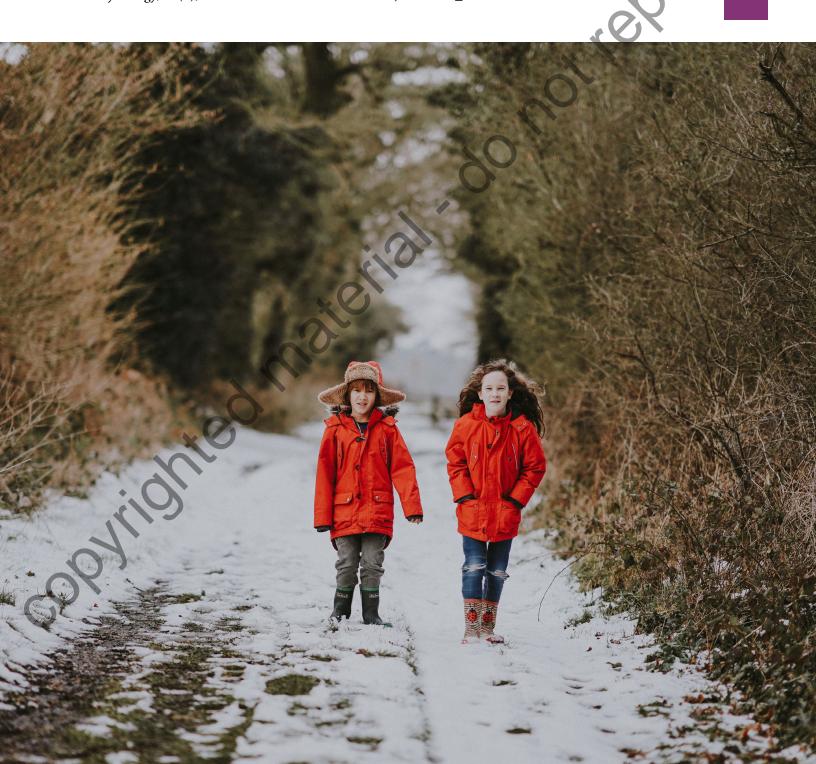
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News of the Organization

Janet Rosenzweig, MS, PhD, MPA, Executive Director

Register NOW for the APSAC 27th Colloquium, June 7 – 11 New Orleans!

Our 2020 Colloquium theme is Strengthening Practice through Knowledge: Promoting Excellence in Prevention, Investigation and Intervention. APSAC's 27th Colloquium will bring high-quality learning opportunities to child maltreatment researchers and practitioners across experience levels and professions.

Registration is now open, so plan to join APSAC at our popular New Orleans venue. Experience our collegial environment and a carefully planned combination of scholarly works and New Orleans excitement!

NEW! An online course featuring more than 20 national experts in child maltreatment!

APSAC and the Vincent J. Fontana Center for Child Protection of the New York Foundling have launched an online course. These eight modules feature 29 individual presentations from experts, including Victor Vieth, David Finkelhor, Jon Conte, Vince Palusci, and Lucy Berliner.

- An Introduction to the Child Welfare System and the Field of Child Maltreatment
- Types of Child Maltreatment/ Effect of Abuse and Neglect
- Medical Evaluation and Diagnosis of Child Abuse and Neglect
- Treatment of Abused and Neglected Children and Their Families

- Understanding and Working Within Public Systems
- Crimes Against Children
- Prevention Models
- Professional Development and Self-Care

Faculty are invited to preview the course for use as a teaching resource; please contact JFRosenzweig@ apsac.org to make arrangements. Low-cost registration is available for an introductory period; **learn more and register here!**

Now available: Resources for families supporting alternative discipline strategies to reduce hitting children

Members of the National Initiative to End Corporal Punishment collaborated on the development of a series of handouts for parents offering practical, safe, and effective alternatives to corporal punishment to use with children of all ages. See samples and order here.

The APSAC/New York Foundling webinar series

On November 20, APSAC and the New York Foundling launched a series of six free webinars featuring national experts on current topics. The inaugural webinar featured Dr. David Finkelhor speaking on Trends in Childhood Adversities: Has Trauma Been Increasing?

Upcoming topics will include Religion and Faith, Trauma-Focused Cognitive Behavioral Therapy, the Impacts of Corporal Punishment, Psychological Maltreatment, and Special Issues in Forensic Interviewing. Watch the APSAC website for the 2020 dates and times!

Did you miss Dr. Finkelhor's webinar? You can watch a recorded version here. *The password to access this webinar is VvYPS3yh.*

APSAC can help with conferences and training

APSAC makes a great partner for a statewide organization planning a conference. Contact Jim Campbell if you'd like us to bring our national resources to your state or community. APSAC is now certified to offer CEUs in certain disciplines, further adding value to your event. We now also offer technical support including online registration and credit card payment processing.

APSAC is making research findings more accessible!

We are proud of the high impact factor of our journal, *Child Maltreatment*, but we know that not everyone has the time or inclination to read entire research articles. This problem is not specific to APSAC; national reports suggest a 20-year gap between generating clinical knowledge through research and use of that knowledge across the mental health and healthcare. To help meet our goal of strengthening practice through knowledge, APSAC is now publishing Research to Practice Briefs to translate research findings published in *Child Maltreatment* into plain language, with an emphasis on implications for practice and policy. All briefs contain an introduction to the issue, a summary of the research questions, a summary of the findings, and the implications for policy and practice. You can find a brief in each *Advisor*, or read all published briefs here.

To join our team of brief writers, volunteer to review student work, or explore bringing this project to a graduate class, contact Bri Stormer.

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Strengthening Practice Through Knowledge

Household Food Insecurity and Parent-to-Child Aggression

Elizabeth J. Gifford, PhD

Original study authors: Jesse J. Helton, Dylan B. Jackson, Brian B. Boutwell, & Michael G. Vaughan

Introduction

In 2015, nearly 17% of households with children in the general U.S. population experienced food insecurity. For roughly a quarter of these households, the level of food insecurity was so severe that food intake was reduced and eating patterns were significantly disrupted. Food insecurity is more common among households who live in poverty. While a large research base has identified household-level poverty as a clear risk factor for child maltreatment, food insecurity is one condition that is closely linked with poverty that may elevate children's risk of experiencing child maltreatment. While food insecurity or food neglect has previously been linked to family violence and poor maternal impulse control, little research has examined whether food insecurity is an independent risk factor of parent-to-child aggression.

Research Questions/ Hypotheses

1. Household food insecurity at baseline measurement will be associated with more severe parent-to-child psychological and physical aggression at follow-up waves of measurement.
2. Food insecurity over two time periods will be associated with higher rates of psychological and physical aggression at follow-up measurement.
3. The relationship between household food

insecurity and parent-to-child aggression will remain even after accounting for measures of maternal depression, impulsiveness, and other socio-economic variables.

Study Sample

The sample for this study (n=2,330) was drawn from the Fragile Families and Child Wellbeing Study, a longitudinal study of births born to mostly unmarried parents in large urban areas. This study relied on data collected in waves 3 and 4 when the target children were aged 3 and 5 years. Measures of parent-to-child aggression were derived from the Conflict Tactics Scale and included psychological aggression, physical aggression, total aggression, and composite aggression.

Findings

Nearly 1 in 4 of the households in this sample reported experiencing food insecurity during at least one of the data collection time points. After accounting for child age, maternal age, race, maternal education, household income, and receipt of public assistance, household food insecurity was associated with increased rates of psychological, physical, and total aggression of caregivers toward their children. The association between household food insecurity and parent-to-child aggression remained even after controlling for maternal impulsivity and depression.

Recommendations

The link between poverty and child maltreatment has been well established. To mitigate the effects

of poverty, a more nuanced understanding of how specific components of poverty relate to child maltreatment is needed. The results of this study suggest that food insecurity is a risk factor for aggressive psychological and physical acts by parents toward their children—even after controlling for household income and other risk factors. The authors suggest that food provision may be an underexamined area in the fields of family violence and child welfare. In particular, the authors posit that providing food may be more feasible politically, socially, and practically than addressing other aspects of poverty such as housing or living wage. According to the authors, increasing the number of at-risk families who are using government and community food assistance programs is critical to fighting child and family hunger, and, if results here are replicated, child maltreatment. Such efforts are not easy, however, as many families who are eligible for the federal Supplemental Nutrition Assistance Program do not participate in this program. Barriers to participation include confusion about eligibility, inconvenience of travel to state health offices, and stigma associated with using the program. Child welfare professionals may be able to facilitate access to formal food assistance programs by helping address these barriers and help families connect with informal food assistance programs such as food pantries.

Bottom Line

Food insecurity is a common experience for United States households. Although more research is needed to understand whether or not food insecurity is an independent risk factor for child maltreatment, evidence is emerging to suggest that household food insecurity may increase parents' aggressive behaviors toward their children. Efforts to alleviate food insecurity among families would positively affect child development and may help prevent child maltreatment.

Citation

Helton, J. J., Jackson, D. B., Boutwell, B. B., & Vaughn, M. G. (2018). Household food insecurity and parent-to-child aggression. *Child Maltreatment 24*(2), 213-221. doi:1077755518819141

About the Author

Elizabeth J. Gifford, PhD, is Assistant Research Professor at the Sanford School of Public Policy at Duke University and Assistant Professor at Duke Pediatrics. She is currently leading the Social and Economics Pillar of the Duke Children's Health and Discovery Initiative.

Conference Calendar

January

January 26, 2020
APSAC's Pre-Conference
Advanced Training Institutes
San Diego, CA
www.apsac.org
In Conjunction with the Rady Chadwick Conference

January 25-31, 2020
35th Annual San Diego International Conference on Child and Family Maltreatment
San Diego, CA
www.sandiegoconference.org

March

March 23-26, 2019
36th International Symposium on Child Abuse
Huntsville, AL
https://symposium.nationalcac.org/

March 25-29, 2020
Child Welfare League of America
"Sharing Ideas that Strengthen Families and Engage Communities to Promote Child Well-Being"
Washington, DC
https://www.cwla.org/cwla2020/

April

April 19-22, 2020
Ray E. Helfer Society Annual Meeting
San Diego, CA
https://www.helfersociety.org/

May

May 27-30, 2020
Association of Family and Conciliation Courts 57th Annual Conference
"When a Child Rejects a Parent: Are We Part of the Problem or the Solution?"
New Orleans, LA
https://www.afccnet.org/

June

June 7-11, 2020
APSAC's 27th Colloquium
"Strengthening Practice through Knowledge: Promoting Excellence in Prevention, Investigation, and Intervention"
New Orleans, LA
www.apsac.org

August

August 3-7, 2020
APSAC Forensic Interview Clinic
New York, NY
www.apsac.org/

August 10-13, 2020
32nd Annual Crimes Against Children Conference
Dallas, TX
http://www.cacconference.org/

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